State of Rhode Island
Department of Children, Youth and Families
Division of Children's Behavioral Health and Education

Standards for Providers of Children's Intensive Services

September 1, 2003

TABLE OF CONTENTS

1.0 SERVICE INFORMATION AND BACKGROUND

For many years the state and its stakeholders have recognized the need for a community and home-based mental and behavioral health program to meet the needs of children with serious emotional and/or behavioral disturbances (SED). All parties agree to the necessity of a full continuum of care options for children. These children often present with mental health issues that threaten to result in placements at more restrictive living arrangements, including settings which may be out of their home and/or out of their community. The primary focus of Children's Intensive Services (CIS) is to provide an array of clinically oriented, community based services and supports, to allow the child to be maintained in the least restrictive living arrangement and, whenever possible, in a family setting. This focus necessitates that treatment address the child's needs in the context of his/her environment, family or other caretaker, school and community. Individual treatment plans outline the clinical combination of direct intensive contact with child, family and/or primary caregivers, and indirect contact including collateral, case management and other additional support. This service is different in type from a single service, such as outpatient therapy, in that it is geared to address the multiple, complex needs of the child and family. Its focus is on the child within the roots of his/her social environment, especially that of the family or substitute caregiver. For this reason, the service is provided within the social environment and dually directed toward the child and his/her caregivers. While the child/youth is the identified client, the presenting conditions of the child, and/or his/her family, determine the level of the intervention of Children's Intensive Services.

During the past fiscal year, approximately 2200 children/youth were enrolled in the current CIS program. As a result of reviewing over 1000 current CIS cases, it is expected that the capacity of the new CIS program will be close to 2000 children/youth and their families on an annual basis. The Certification Standards, including the Levels of Care, were designed using the clinical profiles presented by the children/youth and their families in the current CIS program. These Certification Standards serve to assemble all program requirements within a single document, in order for the State of RI to provide additional structure, quality assurance and accountability for services.

1.1 Introduction

The Rhode Island Department of Children, Youth and Families (DCYF), the state mental health authority for children as set forth in RIGL 42-72-2, and the Rhode Island Department of Human Services, is soliciting applications from qualified organizations to become certified as providers of (CIS) for eligible children with (SED) and their families. The establishment of this certification process and the issuance of these Certification Standards provide the basis for determination of provider-agencies eligible to receive payment for provision of CIS. To be a participating provider-agency of CIS, interested parties including all new provider-agencies and current provider-agencies,-agencies providing CIS on the date of issuance of these standards will need to be certified by the State as CIS providers. These Certification Standards further establish the procedures and requirements for CIS services as administered by DCYF and supercede all previous guidelines, verbal and written, issued by the Department. These standards describe the basis and mechanisms of service delivery, utilization and review, and payment mechanisms for services provided. Currently, there exists one path for authorization of CIS. This is through the

current provider-agencies, all of whom are required to be certified by DCYF to provide CIS. Commencing September 2, 03 all new requests for CIS and their subsequent renewals will be managed by DCYF. DCYF, in overseeing this service, will work in conjunction with the Department of Human Services (DHS), the state Medicaid authority, for the reimbursement of services and wherever Department roles intersect.

These Certification Standards serve to provide families, potential applicants, service providers and other interested parties with a full description of Children's Intensive Services, including guidance as to certification requirements and methods for application. Sections 1 through 4 contain service description and background as follows:

Section 1: Service Information and Background
Section 2: Certification Process
Section 3: Target Population and Location of Service Within the Continuum of Care
Section 4: Service Description- Required Scope of Services

The Certification Standards include two additional sections as follows:

Section 5: Certification Standards
Section 6: Qualified Entity Requirements

Sections 5 and Section 6 specifically describe the requirements for certification. Satisfactory compliance with these requirements must be demonstrated for certification; continuing compliance is required in order to maintain full certification status. Certification applications will be primarily focused on Section 5. Although certified entities must comply with the requirements set forth in Section 6, the requirement to demonstrate such compliance in the application itself is more limited.

1.2 Service Description/Definition

Children's Intensive Services (CIS) is intended to provide an intensive clinical level of services and supports to a child and family to help avoid preventable inpatient admissions, support a child's timely return to the community and provide critical community based supports to children with acute needs. The service consists of a continuum of medically necessary services that are individualized to meet the treatment needs of children with serious emotional and/or behavioral disturbances (SED) and their families. This continuum of Children's Intensive Services includes psychiatric and psychotherapeutic services (including individual, family and group counseling), case management (with the goal of maximizing the child and family's effective use of the full range of services available to them), and therapeutic support services delivered primarily in a family and/or community setting. Medical necessity, as defined and applied to all State Medicaid programs (See: RI DHS Medical Assistance Program, 300-40-3, September 1997) shall mean those services designed to help a child or youth attain or retain the capability to function age appropriately within his or her environment, and shall include services that enhance functional ability. Medically necessary services means medical, surgical or other service required for the prevention, diagnosis, cure, or treatment of a health related condition including such services necessary to prevent a decremental change in medical or mental health

status. These services must be provided in the most cost effective and clinically appropriate setting in the community.
There will be no catchment areas or waiting lists. Families will have their choice of CIS providers.

DCYF and the State are committed to ensuring the availability of responsive, high quality behavioral health services to eligible children and their families. CIS provides a comprehensive approach to meeting the needs of SED children and their caregivers, through the offering of a flexible array of services and supports that have been successful in ameliorating the emotional and behavioral challenges, and allowing children and youth to remain in the least restrictive living arrangement. These standards reflect a redefinition of Children's Intensive Services, as they currently exist, through the incorporation of four clearly defined levels of intensity of service. The four levels of care are: Crisis Management/Stabilization; Standard; Intermediate Care; and Maintenance. An overview of criteria for each level of service is contained below in sections 1.2.1 through 1.2.6. The complete levels of care are contained in Attachment A.

1.2.1 Admission Criteria

Eligibility for (CIS) for all levels must be based on the child's having a DSM (current edition) Axis I or Axis II diagnosis and a major functional impairment (*defined as a substantial interference with or limitation of a child's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills*), which has lasted or is expected to last at least one year; and child is at risk for out-of-home placement or placement in a more restrictive setting (due to presenting concerns with behavior).The definition of major functional impairment could be measured on the Global Assessment of Relational Functioning (GARF) Scale as found in the DSM IV. Scores below 41 on this scale would be considered to be significant. The vendor can identify another similar scale to measure this impairment which is a similar tool and agreed to by DCYF (such as may be found in the Childhood Disability Evaluation Form utilized by the Social Security Administration) and based on the following: a DSM IV multi-axial evaluation with an Axis I or Axis II diagnosis and an Axis V score based on the Children's Global Assessment Scale (CGAS) identified within the levels of care and meet criteria for Serious Emotional Disturbance (SED)[1] , as defined in RIGL 42-72-5(b)(24)(v)[2]; or emotional disturbance as found in the Individuals with Disabilities Education Act (IDEA), 34CFR300.7(c)(4).

[1] 34CFR 300.7 (c)(4) state that emotional disturbance is defined as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; a tendency to develop physical symptoms or fears associated with personal or school problems; the term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

[2] RIGL 42-72-5 (b)(24)(v) states that a child has a mental health, emotional or behavioral diagnosis under the current edition of the Diagnostic and Statistical Manual (DSM) which has lasted for or can be expected to last for at least one year, and is at risk for more restrictive placement, including, psychiatric hospitalization, as a result of this condition for which other less intensive levels of service have not been effective (e.g. outpatient services).

Level 1- Crisis Management/Stabilization:

- Child may enter through each provider's intake/screening process as a new CIS intervention, or may transition from a less intensive level of care as an ongoing CIS intervention.
- Child and family is experiencing a behavioral; psychiatric; and/or developmental crisis that threatens the child's ability to remain in or move to a less restrictive living environment.
- The Children's Global Assessment Functioning (CGAS) scale score is between 10 and 30.
- Child has a major impairment in functioning in three or more areas as identified in the GARF (or approved alternative tool) and is unable to function in at least two settings (e.g., home, school, peer interaction).

Level 2- Standard

- Child and family service need has transitioned from a more or less intensive level of care; or
- Child and family has multiple needs, for which other less intensive levels of service have not been effective; (e.g., regularly scheduled weekly outpatient therapy);
- The Children's Global Assessment Functioning (CGAS) scale score is between 31 and 40;
- Child has a moderate degree of impaired functioning in most social areas or severe impairment in one area (e.g., home, school, peer interaction).

Level 3- Intermediate Care

- Child and family has transitioned from a more intensive or less intensive level of care.
- The Children's Global Assessment Functioning (CGAS) scale score is between 41 and 50.
- Child has variable functioning with sporadic difficulties or symptoms in several but not all psychosocial areas.
- Child and family have multiple needs, which are unable to be addressed through a single service (i.e., outpatient).
- Child and family have identifiable and available useful supports in community.

Level 4- Maintenance

- Child and family has transitioned from a higher level of care, or has had a prior CIS intervention.
- There will be no direct entry to this level, except in cases of CIS intervention that have closed within the previous 12 months (as deemed appropriate).
- The Children's Global Assessment Functioning (CGAS) scale score between is 51 and 60.
- Child has some difficulty in a single area, but generally functioning well.
- Services will include case management, provided at home and community, to maintain and reinforce gains made at previous levels of CIS.

- This level should transition to be supportive and complementary to outpatient clinical services, such as psychiatric medication management and office-based psychotherapy that are funded through the child's health insurance and RIte Care Plans.

1.2.2 Risk Criteria

Level 1- Crisis Management/Stabilization:

Very High Risk in crisis

- Crisis requires behavioral health intervention and assessment to ensure safety of child and family.
- Actual or potential danger is such as to present immediate danger to the child/family, or to others in contact with the child/family.

High to Moderate Risk in stabilization

- Child is exhibiting behavior, expressing thoughts or presenting with impaired judgment, that make it possible that harm will occur, but there is no immediate risk of violence or self-harm.
- Situation is not imminently life threatening.
- Child, or other family member, expresses thoughts of dangerous ideation but denies intent to follow through.

Level 2- Standard

- Child, or other family member has moderate to severe psychiatric symptoms and is experiencing moderate to severe psychosocial stressors.
- Child, or other family member has moderate to severe impairment in areas of functioning such as self-care, family living, school, social relations, etc.
- Psychiatric symptoms may be stable and there is no presence of suicidality or self harming behavior.
- Child and family have limited social support and self support network is under significant stress.
- Child and family exhibits poor coping skills.

Level 3- Intermediate Care

- Child, or other family member, has moderate psychiatric symptoms and is experiencing moderate psychosocial stressors.
- Child, or other family member, has moderate impairment in areas of functioning such as self care, family living, school, social relations, etc.
- Mild risk of danger.
- Psychiatric symptoms may be stable and there is no presence of suicidality or self harming behavior.
- Child and family exhibits poor coping skills.
- Child and family has identified social support network and self support network is under moderate stress.

Level 4- Maintenance

- Situation does not present any physical danger or risk.
- Child, or other family member is having mild psychiatric symptoms.
- Child, or other family member has mild impairment in areas of functioning such as self-care, family living, school, social relations, etc.
- Child and family has identified, intact social support network and self support network is under mild stress.
- Risk for regression to higher level of need if supports that ensure access to essential services are not provided at this level.

1.2.3 Frequency and Duration

Level 1- Crisis Management/Stabilization:

<u>During Crisis Intervention</u>

- Twenty four hour, 7 day per week face-to-face emergency crisis intervention services must be available as needed, with a minimum of telephone contact within 15 minutes of presentation of crisis and face to face contact within 2 hours of presentation of crisis.
- Intense staff participation (face to face with family and indirect (including telephone) with collaterals and team), within a 24 hour period.
- A crisis management plan will be developed within 24 hours of initial contact. Plan is made with child and family and includes strategies for dealing with escalated crisis over the next 24 hours.

<u>During Crisis Stabilization</u>

- Six - 14 hours per week of direct, clinical, intensive face to face contact with child, family and/or primary caregivers, provided by team.
- Any services provided at less than a minimum of 6 hours per week, should transition to Level 2.

Level 2- Standard

- This level will provide flexible hours of service provided by a team ranging between 2 to 10 hours per week, depending on whether there are multiple children in home who are also receiving CIS services, or whether services are tailored to a single child.

Level 3- Intermediate Care

- This level will provide flexible hours of service provided by a team ranging between 2 to 5 hours per week, depending on whether there are multiple children in home who are also receiving CIS services, or whether services are tailored to a single child.
- This service extends the continuity of care in CIS for child and family, needing individual, group, or family therapy.
- This service serves as a collaborative link to other community based systems, in order to continue the child's transition to less intensive levels of care, including to Level 4 or to the health plan, if clinically appropriate.

Level 4- Maintenance

- This level will provide flexible hours of service provided by a team, of 30 minutes per week.
- This service provides outreach and follow-up services for longer-term involvement and support.
- Expectation is 2 hours per month of case management/ collateral support.
- The clinical program goal of Level 4 is to transition the child and family to an in plan service if clinically appropriate and/or to other community supports.

1.2.4 Length of Service

Level 1- Crisis Management/Stabilization:

- Sustained involvement should last no more than two weeks (14 days) and transition to less intensive treatment must occur.

Level 2- Standard

- Length of stay is expected to be 1 to 3 months.
- Additional time may be needed, however, it will require an approved extension request from the State, see Section 5.6.3., as determined through a Treatment Plan review based upon the following criteria:
    - Child and family continue to meet admission criteria for this level of care and less intensive care is not adequate to address child and family risk factors.
    - For children aged 18 to 21 who are eligible for adult mental health services, transition to those services will be initiated.

Level 3- Intermediate Care, length of stay is expected at from 3 to 6 months

- Continued stay may be appropriate, however it will require an approved extension request from the State, see Section 5.6.3, as determined through a Treatment Plan review, based upon the following criteria:
    - Child and /family continues to meet admission criteria for this level of care and less intensive care is not adequate to address child and family risk factors.
    - For children aged 18 to 21 who are eligible for adult mental health services, transition to those services will be initiated.

Level 4- Maintenance

- This level of care is intended to maintain the stability achieved at higher levels of CIS care.
- Continued stay, maximum time period of 6 months, may be appropriate, however, it will require an approved extension request from the State, see Section 5.6.3, as determined through the treatment plan review, based upon the following criteria:
    - Child and family continues to meet admission criteria for this level of care and other community based services are not appropriate.
    - For youth aged 18 to 21 who are eligible for adult mental health services, transition to those services will be initiated.

1.2.5 Service Components

Level 1- Crisis Management/Stabilization:
<u>During Crisis Management</u>

- The level and nature of the crisis will be assessed and a crisis management plan will be developed.
- Available family and community supports will be identified and mobilized, as part of the crisis management plan.

<u>During Stabilization</u>

- Services at this level should be provided over 85% of the time by a Masters Level (or above) clinical practitioner.
- The following services will be provided and coordinated:
    - Crisis Stabilization
    - Crisis assessment/intervention
    - Medication evaluation
    - Therapeutic case management, with clinical oversight by the team leader (LICSW clinician or higher)
    - Clinical Supervision
    - Treatment Consultation
    - Service Coordination-including active collaboration with appropriate LEAs, primary care physicians, health insurers, CEDARRs, DCYF staff and others.
- Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the care giver of the primary client or in the community e.g., hospital, school, foster home, group home, office).
- Clinical and administrative triage by lead clinician, in consultation with clinical supervisor, should be conducted on a daily basis. This is in addition to any formal supervision.

Level 2- Standard

- Services, at this level, shall be provided at least 80% of the time by a Masters Level-(or above)clinical practitioner. If services fall below this level, the child should be transitioned to a less intensive level of care.
- The following services will be provided and coordinated:
    - Comprehensive Family Assessment and/or Reassessment, in which the level and functioning of family as a whole, will be assessed.
    - Development of detailed, individualized treatment plan.
    - Home and/or community based (including the appropriate school setting), intensive therapeutic treatment as prescribed by the clinical treatment plan from a masters' level or higher clinician;.
    - Therapeutic case management, with clinical oversight by the team leader (LICSW level or higher clinician).
    - Clinical Supervision.
    - Treatment Consultation.
    - Service Coordination, including:

        - Coordination of any educational and medical needs.
        - Therapeutic support services.
        - Coordination with additional support systems, i.e. CASSP, CEDARR, LEA, health plans, informal and formal family supports, DCYF.
        - Transition out of CIS to health plan if clinically appropriate-involves collaboration with "receiving agency".
- Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g., office, school, foster home, group home).

Level 3- Intermediate Care

- Services, at this level, shall be provided at least 60% of the time by a Masters level practitioner or above. If services fall below this level, the child should be transitioned to a less intensive level of care.
- The following services will be provided and coordinated:
    - Comprehensive Family Assessment and/or Reassessment, in which the level and functioning of family as a whole, will be assessed.
    - Development of detailed, individualized treatment plan.
    - Home and/or community based (including the appropriate school setting) intensive therapeutic treatment as prescribed by the clinical treatment plan from a masters level or higher clinician trained in this discipline.
    - Therapeutic case management, with clinical oversight by the team lead (masters level or higher clinician).
    - Clinical Supervision.
    - Treatment Consultation.
    - Service Coordination, including:
        - Coordination of any educational and medical needs;
        - Therapeutic support services;
        - Coordination with additional support systems, i.e. CASSP, CEDARR, LEA, health plans, informal and formal family supports;
        - Transition out of CIS.

- Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g. office, school, foster home, group home, hospital).

Level 4- Maintenance

- Services at this level, shall complement other ancillary services available to child and family (e.g.,CASSP), in order to be mindful of the need to transition the child and family to a less intensive level of care if clinically appropriate.
- The following services will be provided and coordinated:
    - Comprehensive Family Reassessment, in which the level and functioning of family as a whole, will be assessed.
    - Development of detailed, individualized treatment plan.
    - Home and/or community based intensive therapeutic treatment as prescribed by the clinical treatment plan from a masters' level or higher clinician trained in this discipline.

- Therapeutic case management, with clinical oversight by the team lead (masters level or higher clinician).
- Clinical Supervision.
- Treatment Consultation.
- Service Coordination, including:
  - Coordination of any educational and medical needs;
  - Therapeutic support services;
  - Coordination with additional support systems, i.e. CASSP, CEDARR. LEA, health plans, informal and formal family supports, DCYF;

- Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g., office, school, foster home, group home, hospital).

1.2.6 Discharge Criteria

Level 1- Crisis Management/Stabilization:

- Child and family no longer meet admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care.
- Child and family crisis management plan goals have been met.
- Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity.

Level 2- Standard

- Child and family no longer meet admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care.
- Child and family treatment plan goals have been met.
- Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity.

Level 3- Intermediate Care

- Child and family no longer meets admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care
- Child and family treatment plan goals have been met

- Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity

Level 4- Maintenance

- Child and family no longer meet admission criteria for this level.
- A reassessment of the appropriate level of care requires a higher or less intensive level of care.
- Child and family is referred to outpatient counseling services, or other less intensive level of care that is sufficient to meet their needs.
- Child and family treatment plan goals have been met.

1.2.7 Temporary Discharge

If a child/youth and the family are unavailable for services the CIS case should identified as Temporarily Closed. The longest time period a CIS case can be in this category is ten (10) days. This time frame can be extended by the State for additional ten (10) days, following the extension Criteria as described in Section 5.6.3.

1.3 Intended Outcomes

The availability of Children's Intensive Services will result in:

- Maintenance of the child in the least restrictive living arrangement, preferably in a family setting in the community;
- Continuity of care for children presenting with SED and behavioral health issues;
- Improved coordination of care, with those providers, service systems and payers whose services may support children, and their families, presenting with SED and behavioral health issues;
- Reduction of inpatient psychiatric hospital admissions and readmissions;
- Child focused and family centered intervention;
- Appropriate and timely service provision based upon defined levels of care;
- Improved functioning by child, as determined by CGAS and/or CAFAS;
- Parent/child satisfaction, as determined by survey tool administered at discharge.

1.4 Data Reporting Elements

Providers of Children's Intensive Services will be subject to the following data measures (reported in the aggregate), which will include, on a quarterly basis:

- Percentage of Treatment Plans Developed-within timelines found in the Standards.
- Percentage of Treatment Plans Implemented- within timelines found in the Standards.
- Percentage of Treatment Plan Goals met-within timelines found in the Standards.
- Percentage of Children and Youth transitioned to an In Plan service, where appropriate, within six months.
- Percentage of Children and Youth who remain in original living situation.
- Percentage of Children and Youth transitioned to a lesser restrictive living situation.
- Percentages of CIS extensions requested.
- Percentage of CIS extensions granted.
- Percentage of referrals from psychiatric hospitals.

1.4.1 OUTCOME MEASURES

Providers of Children's Intensive Services will comply with the DCYF Performance Indicator process, in addition, the Performance Measures to achieve CIS program outcomes will include:

- Percent of cases where services are initiated within Levels of Care required time frames, based on date of initial contact;
- Percent of cases with contact events with family members, other than identified child;
- Percent of cases with home-based CIS clinical intervention;

- Percentage of cases with school based CIS program intervention;
- Percent of cases at each Level of Care;
- Percent of cases involving psychiatric hospital admissions, during CIS involvement, by Level of Care;
- Percent of cases involving out of home placement, during CIS involvement, by Level.

1.5 Authorization and Reimbursement

CIS requires for entrance into Level 1, within 48-72 hours after admission, the submission of the Crisis Management Plan to DCYF for Clinical/Administrative Review, in order to be reimbursed for services. The DCYF Review will be solely focused upon whether the child meets the eligibility criteria of Level 1, as set forth in the levels of care only and will not serve to authorize treatment plans. However no Crisis Management Plan will continue to be funded by DCYF if the review cannot document this level of intervention. CIS providers are required to complete their Crisis Management Plan (as referenced in the Levels of Care) and send this form via fax to DCYF. The Crisis Management Plan should include:

- A detailed narrative of the behavioral; psychiatric; and/or functional crisis that threatens the child's ability to remain in or move to a less restrictive living environment;
- A detailed narrative of the child's ability to function at home, at school, in the community and with peers, with GARF score;
- The child's Children's Global Assessment Scale (CGAS) score, at intake;
- An overview of the steps that will be taken by the CIS intervention, to address the child's identified issues.

After the Review of the Crisis Management Plan, DCYF will issue a written response to the CIS provider, within 12-24 hours. This Review will review compliance with the Standards at Level 1 and will provide approval of authorization of services for up to two weeks, which is the maximum length of stay for Level 1, as set forth in the Levels of Care. Services provided after a denial of an authorization shall not be reimbursed. The Review process will comply with patient privacy guidelines, as set forth in the Health Insurance Portability and Accountability Act (HIPAA).

Direct entry to levels, other than Level 1, are subject to the eligibility criteria set forth in the levels of care, but do not have to follow the same review process as in Level 1. Service at these levels may, however, be subject to periodic DCYF Clinical Record audits as well as site visit UR activity.

1.5.1 Period of Authorized Service and Process for Service Extension

The initial period of a CIS intervention may range from 2 weeks to 6 months, as is determined by the level of care at entry. There is the potential to receive an extension of CIS for an additional six months, for a maximum of 12 months of service, after prior authorization from DCYF. There will be no continuous stay for a child in CIS beyond 12 months.

When seeking an extension of CIS services, the provider must demonstrate how CIS can maximize the achievement of goals and improved functioning for the child and, when appropriate, the family within a specified period of time. This means reviewing methods of intervention and ensuring that best practices are followed. The latter must also address the use of other professional services (e.g., individual or family therapy, consultation with a child psychiatrist) as well as a re-examination of treatment objectives and treatment intensity when formulating requests for extensions.

In order to receive an extension of service, CIS providers must submit a written request detailing what specific treatment goals remain to be accomplished and in what time frame these can be accomplished. Extensions should be sought to offset a decremental change in child's functioning and/or to prevent their immediate relapse. Extensions should acknowledge the goal of transitioning the child from CIS, and CIS should serve as the program of last resort. DCYF will grant authorization for a time limited period based upon the necessity to accomplish these specific treatment goals. Requests for extensions should be reviewed, based upon best clinical practice, internally by the CIS provider, prior to forwarding to DCYF. Requests should be forwarded to DCYF at least two weeks prior to the originally identified discharge date.

2.0 CERTIFICATION PROCESS

2.1 Submission of Certification Application Required

To be eligible for reimbursement for Children's Intensive Services in Rhode Island, any willing provider must be certified by DCYF, through a rolling open enrollment process, as a Children's Intensive Services provider.

There is no limit to the number of entities that may become certified as provider-agencies of CIS. Applications for certification may be submitted by agencies providing CIS services prior to the issuance of these standards or by any other entity seeking to become a provider of CIS. All CIS applicants will be evaluated on the basis of written materials submitted to DCYF addressing Certification Standards. DCYF reserves the right to conduct on-site reviews and to seek additional clarifications prior to final scoring.

Potential applicants may submit applications for certification to DCYF any time after the issuance of these Certification Standards. Reviews will be scheduled periodically by DCYF based on receipt of applications. Provider-agencies will be notified of their certification status when the review is complete. Applicants should anticipate a one month amount of time for the review process.
During the initial period of application review and certification, subsequent to the issuance of these standards DCYF sets forth the following schedule. CIS provider-agency certification applications must be received by DCYF by September 26, 2003 in order for the provider-agency to become certified by October 31, 2003. Provider-agencies submitting applications by September 26, 2003 will be informed regarding certification status no later than October 31, 2003.

2.2 Instructions and Notifications to Applicants

This document sets forth the certification standards for providers of Children's Intensive Services. In accepting certification from DCYF, Certified providers agree to comply with these certification standards as presently issued and as amended from time to time by DCYF, with reasonable notice to providers.

These certification standards also serve as the application guide. Sections 4.2, 5 and 6 of this document identify the standards against which applicants will be evaluated. Applications will be scored on the basis of responses to each of these specific standards and expectations. These Certification Standards are to be scored based in the level of the applicant's described ability presented in the Application to meet the eight (8) Service Components-as described in Section 4.2. In addition to the core standards, the organizational capacity of each Applicant will be evaluated as well as its ability to be HIPPA compliant, Family Centered throughout its design, and provide evidence all appropriate timelines can be met.

Applicants are to address each of the areas in the sequence presented herein. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these certification standards will be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

Interested parties are encouraged to contact the DCYF Children's Behavioral Health (CBH) Division for further information and clarification. Letters of Interest are strongly encouraged to ensure that DCYF is able to keep interested parties up to date regarding scheduled meetings or program clarifications that may be needed. Inquiries, Letters of Interest and completed applications should be directed to:

Janet Anderson, Ed.D., Assistant Director
Department of Children, Youth and Families
Children's Behavioral Health and Education (CBH&E)
101 Friendship Street, 3rd Floor
Providence, Rhode Island 02903
(401) 528-3797

DCYF will convene a CIS Certification Application Review Committee to evaluate applications and make recommendations on certification to Dr. Janet Anderson, Assistant Director, DCYF Children's Behavioral Health and Education Division. Based on a positive action, a letter will be sent to the application agency offering certification to the agency and identifying any conditions to the certification. A signed acceptance of certification is required. This certification process should be completed within thirty (30) days of the State receiving a completed Certification Application from a potential vendor.

An additional amount of time may be required for the State to collaboratively work with an applicant whose proposal in its original form does not meet the minimum Certification Standards, as determined by the CIS Certification Application Review Committee. Once a

provider is certified as eligible to provide CIS, the provider shall be enrolled with DCYF as a provider of these services.

2.3 Information for Interested Parties

Upon initial release of these CIS Provider Certification Standards, DCYF staff will be available to provide information for those pursuing certification applications. If appropriate, DCYF will provide written addenda to these standards to further clarify certification requirements.

2.4 Certification

As set forth in these standards, certification as a CIS provider is required in order for DCYF to reimburse a provider agency for provision of CIS services. Certification requires that provider-agencies adhere to these standards and performance expectations, as well as provide periodic reports to DCYF. These Certification Standards include certain performance standards.
Subsequent to certification DCYF will monitor the performance of certified CIS provider agencies and their continued compliance with certification requirements. Certified agencies are required to notify DCYF of any material changes in their organizations circumstances or in program operations. On the basis of ongoing monitoring, including review of required reports submitted by certified provider-agencies, DCYF might identify deficiencies in performance and/or compliance with certification requirements. Based on such review and related communications, certification status may be modified to Provisional Certification.

2.4.1 Possible Outcomes of Certification Review Process

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a program that complies with the requirements set forth in these CIS Certification Standards.

Three basic outcomes are possible as a result of the application review process. These are:

- Certification with no conditions
- Certification with conditions
- Not certified

As a result of the review, provider-agencies may be deemed in compliance with all requirements and be offered "Certification with no conditions". Alternatively, an applicant may describe a program that meets most of the Certification Standards, but for one reason or another does not fully comply with the certification requirements at the time of application submission. In such case the applicant may be offered "Certification with conditions" and application deficiencies will be identified by the State. The applicant will be required to address them by submitting a corrective action plan with specific dates for addressing deficient areas of compliance. This plan must be accepted and approved by the State. In no case will a potential vendor in the Not Certified status, or the Certified with conditions status, be allowed to enroll children and families, provide any CIS service or bill the Medicaid authority for any such activity.

2.4.2 Certification with conditions.

In cases the review team may determine that an application does not meet the requirements for certification and certification will not be offered to that agency. Deficiencies in the application will be identified. This will be done without prejudice and interested applicants will be encouraged to address deficiencies and submit an amended application. Certification is not a competitive process limited to a fixed number of providers. Rather, all applicants which demonstrate preparedness to comply with the standards will be certified

2. 4.2.1 Period of Certification

The first period of certification will begin no earlier than September 15, 2003. Certification will be granted for a 3-year period. Extension of certification beyond the 3-year period will be granted based on a new certification application for an additional period.

2.5 Continued Compliance with Certification Standards

Certified CIS providers shall comply with these CIS Certification Standards throughout the period of certification. Failure of DCYF to insist on strict compliance with all certification standards and performance standards shall not constitute a waiver of any of the provisions of these certification standards and shall not limit DCYF right to insist on such compliance. DCYF, in conjunction with the Department of Human Services (DHS), reserves the right to monitor and evaluate provider-agencies of CIS for compliance with Medicaid and State laws, as well as these Standards and DCYF regulations and policies, CIS providers are required to provide periodic reports to DCYF as identified in Section 5.11, "Service Monitoring/Reporting". For purposes of review, certified and provisionally certified providers will provide access to DCYF and/or its agents at reasonable times to appropriate personnel and written records. The State reserves the right to apply a range of sanctions to providers, which are out of compliance. These may include:

- Suspending new referrals.
- Change of certification status to Provisional Certification.
- Recumbent of funds when violations of Medicaid regulations, State law, or DCYF policies, including these Certification Standards have taken place.
- Dependent on severity of violation, suspension of certification.
- Referral to appropriate legal authorities.

2.5.1 Provisional Certification

As a result of its review activities DCYF may identify deficiencies wherein an agency is not in satisfactory compliance with the certification and/or performance standards. In such instance, DCYF will notify the agency in writing of such deficiencies and will set forth a period of time within which the agency must come into compliance or provide a corrective action plan acceptable to DCYF. Such corrective action plan will include specific steps to be taken to come into compliance and defined dates for achievement of those steps.

The length of the period set to come into compliance or to have a corrective action plan accepted by DCYF will depend on the specific circumstances. In exceptional circumstances, for example, where the safety of a child is in jeopardy, such a period may be as short as twenty- four (24) hours; under no circumstances shall the period exceed thirty (30) days from the date of notification of deficiency.

In the absence of a plan acceptable to State or in the event of failure to meet the timelines set forth in the corrective action plan, the State retains the right to modify certification status of the agency to provisional. Provisional Certification will remain in effect until the State determines that there is, in its judgment, satisfactory resolution of deficiencies. The duration of Provisional Certification status shall not exceed three months at which point continued non-compliance with the State requirements shall result in de-certification. The foregoing represents the State's preference to engage in constructive remedial activity where deficiencies may be present. The foregoing shall not, however, limit State rights to de-certify a provider in the event of non-compliance and failure to take responsive action to address deficiencies. Nor does it limit any remedies available to the State of RI under existing federal and state Medicaid law and policy.

2.6 Transition Plans for Children Served by Agencies Not Seeking or Not Achieving Certification – Special Designation

In order for agencies to receive reimbursement for services rendered after November 30, 2003, the Agency must be certified. There are two reasons that an existing provider may not be certified as of that date:

- The agency has chosen not to apply for certification;
- The agency has applied for certification but the agency has not been certified.

In these cases, the time period for reimbursement by the State of RI may be extended through Special Designation for services provided through December 31, 2003. The purpose of this Special Designation would be to support continuity of treatment for affected children and to effect an orderly transition. Special Designation will enable an agency to be reimbursed for authorized services for specified children for services provided between September 2, 2003 and December 31, 2003. This will apply to services for children for whom a Child Specific Transition Plan has been provided to, and approved by, DCYF.
Any agency, which makes a decision not to apply for certification prior to that date, is requested to notify DCYF at the earliest point possible so that transition plans can be arranged. In the event that an agency does make timely application for certification but that application is not approved, Child Specific Transition Plans are to be submitted within thirty (30) days following notification by DCYF. The State of RI will work to promote continuity of care for children and will work collaboratively with agencies if circumstances exist which could allow the agency to promptly address certification deficiencies.

2.7 Licensure Requirements for Service Providers in Certified CIS Provider Agencies

A requirement for certification is that all clinical staff engaging in providing clinical supervision or treatment consultation must be health care professionals licensed by the Department of Health

(DOH) of Rhode Island. In addition, licensed clinical staff must be able to demonstrate clinical competence to render treatment consultation or clinical supervision to direct service staff. Note that a list of clinical staff, their disciplines and license/certification number must be included in the application for Certification (see Section 5.8.3.1).

2.8 DCYF Responsibilities

DCYF has the responsibility to inform appropriate State agencies of any instances of fraud, suspected fraud or misuse of Medicaid funds and professional misconduct. As a Medicaid provider, the provider-agency is obligated to comply with all applicable state and federal rules and regulations. Certified provider-agencies agree to comply with DCYF program requirements. DCYF reserves the right to amend program requirements from time to time, with reasonable notice to participating provider-agencies.

2.8.1 Oversight and Authorization

DCYF may place limits on services (e.g., establish amount, duration, and scope of services) and exclude any item or service that it determines is not medically necessary, is unsafe, experimental, or is not generally recognized as an accepted method of medical practice or treatment.

3.0 TARGET POPULATION AND LOCATION OF SERVICE WITHIN CONTINUUM OF CARE

3.1 Eligibility and Levels of Care

Eligibility is based on four clearly defined levels of care (discussed in further detail in Attachment A). Each eligible child must have a completed multi-axial evaluation with an Axis I or II diagnosis, under the current edition of the Diagnostic and Statistical Manual (DSM-IV), a major functional impairment (*defined as a substantial interference with or limitation of a child's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills*- (see GARF Scale, and a Children's Global Assessment Functioning (CGAS) scale score). The range of the CGAS score, along with the level of risk determination, will determine the appropriate level of care. Movement between levels will be determined through a utilization management process, which will be conducted by each provider on a consistent basis, through measurement of specific treatment plan goals against level(s) of care continued stay criteria. Child and Adolescent Functioning Assessment Scale (CAFAS) must be applied to determine level of care. The utilization management process is described in detail in section 5.9. In addition, DCYF will be conducting monthly on site Utilization visits to ensure compliance and to work in a collaborative manner with the provider to provide any needed Clinical/Administrative technical Assistance.

3.2 Children's Intensive Services Within the Continuum of Care

Any child between the ages of birth to twenty-one (21) may be eligible to receive Children's Intensive Services if they meet the criteria for serious emotional and/or behavioral disorder

(SED) as defined in 34CFR 300.7 (c)(4)[3], and in RIGL 42-72-5 (b)(24)(v)[4]. DCYF and CIS providers will coordinate and collaborate with the Department of Health (DOH) and Early Intervention providers, on an as needed basis, for any child between the ages of birth to three (3), who may meet the eligibility criteria for both services. The birth to three (3) population is a specialized population that may present with serious behavioral health needs, but may not always meet all eligible CIS criteria. For this reason, this population should be reviewed with additional focus at the screening and intake process.

Within the continuum of care, Children's Intensive Services provides the level of intensity for children presenting with moderate to high risk, as described in the levels of care, contained within Attachment A of this document. The service may be delivered in the home, in the community or as a support to substitute care. Within the context of the Children's Intensive Services levels of care, there is transition planning, based upon the utilization management process, to determine movement between levels and to determine aftercare services, as appropriate.

3.3 Size of Target Population and Estimated Level of Service Need

The target population for Children's Intensive Services consists of the potential number of children who may be receiving this service. Currently, there are approximately 2200 children receiving this service on an annual basis in Rhode Island. This is an increase from ten years ago, when 1000 children were serviced. An expectation of the Certified CIS program is that the population should be reduced by 11% from the current number of children and families in the existing CIS program. The criteria for this target population are set forth below.

Based on the prevalence estimates by the United State Surgeon General, it is calculated by DCYF that 49,600 children under age 18 will meet DSM-IV diagnostic criteria and 12,400 children under 18 will be likely to have an extreme functioning impairment, such as serious emotional disturbance. These estimated figures are based on the total number of children in Rhode Island under the age of 18, according to the 2000 census.

Beyond the determined eligibility criteria, it is estimated that as many as two-thirds of children receiving Children's Intensive Services have a family history of abuse, trauma or neglect, and live in a home whose family income falls within Rhode Island poverty guidelines. Children's Intensive Services clients have varying degrees of problematic/dangerous behaviors based upon difficulties with a number of life domains. These may include school difficulties, legal problems, care givers with their own behavioral health care issues, poor levels of consistency in the home, and substance abuse. The treatment that the program offers may include many dimensions and often includes treatment for other family members through coordination with other services and systems of care.

4.0 SERVICE DESCRIPTION- REQUIRED SCOPE OF SERVICES

4.1 Service Name and Definition

Children's Intensive Services are comprehensive in nature and encourage flexibility on the part of the provider in the development and implementation of the treatment plan. Services will be delivered in home or community based settings, whenever possible and as prescribed by the individual treatment plan, and subject to safety considerations and the preference of the child and/or family. The level of care set forth in the treatment plan will determine the mix and intensity of services provided.

4.2 Service Components

The scope of services within CIS, in specified amounts as set forth in an approved CIS treatment plan, can include the following reimbursable services:

1 *Crisis stabilization and 24 hour crisis assessment/intervention*

- This service will consist of a response to an emergency or crisis, which is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, is time limited in intensity and duration, and poses serious risk of harm to the individual or others.
- Crisis management plans should include measurable goals and objectives geared toward moving the child to the next level of care

2 *Medication evaluation*

- This service will assess the need for psychotropic medication as determined through a medication evaluation completed by a board eligible child psychiatrist, or clinical nurse practitioner, trained in child and family services, with prescriptive privileges.
- All children must have a current physical examination performed by their primary Care Physician or in the process of having one completed. This requirement holds for all Levels of CIS involvement.

3 *Development of family assessment and/or reassessment* (reassessment will occur only if previous CIS involvement within last 12 months)

Assessments will be detailed, comprehensive and based on established standards of clinical practices. Components of the assessment should include:

The child's psychiatric diagnosis; Assessment of child's condition and level of risk; Need for psychotropic medication, Caregivers' understanding of child's strengths and their needs and difficulties in meeting those needs; Current stressors on child and family and supports available to them; Family's ability and willingness to engage in proposed treatment; Strengths and difficulties in child and family's interaction with the larger environment (e.g. school, legal system, peer groups); Child focused and family centered intervention; The availability and effectiveness of other service providers, systems of care and payers in supporting the child and family in treatment; Relationship with systems and providers, including delineation of how services will not be duplicative; Identification of what appropriate aftercare services are anticipated to be and how the client/family will be transitioned to them when appropriate.

4 *Development of a detailed individual treatment plan*
Based on measurable and specific goals. The plan will be based on the comprehensive assessment of child and family strengths and needs; and will include a continuum of services and will be updated as per the utilization management process included in the levels of care standards; an integral part of the individualized treatment plan and assessment includes intimate coordination with other appropriate agencies, family/ community resources in order to maximize the service benefit for the child and family.

5 *Intensive therapeutic treatment*
These services may include:

Medication management, individual, group and family counseling; individual, group and family psychotherapy; and coordination with other systems, which are critical in the life of the child and/or their family.

Services provided by non-clinical staff as part of a closely supervised clinical program focused on working with the child and family on specific behavioral health issues in the home setting, assisting the caretaker and family during stressful times, providing the caretaker with strategies to successfully deal with these situations, medication compliance, medication, LEA coordination, development and maintenance of daily living and life skills.

6 *Delivery of therapeutic case management services*
These services may include:

System navigation, resource analysis, and child and family advocacy. The program will be proactive in developing and nurturing collaboration with other services providers, systems and payers;

Child and family support services which assist the parents of the child to identify social-emotional needs and develop family interpersonal relationships which will allow child to remain at or return to the least restrictive living situation, whenever possible in a family setting. Such services are directed toward reducing symptomatology, maintaining or improving family quality of life and family intactness, and diminishing stress on the primary caregiver and the family environment. Family supports and service can include therapeutic respite provided by trained non-clinical personnel, whose activities will be directed by a clinician, on a short term basis; and activities directed at linking families with other families for additional support activities.

7 *Service coordination services*
These services may include:
Provision of community based support services for the youth and family, which assist in the attainment of treatment plan goals and objectives. These are services which form a part of the individual treatment program designed to meet the mental and behavioral health needs of the child and family and may include activities considered essential to the success of the therapeutic program such as taking the youth out of the home for in-community and/or

school-based therapeutic activities, assistance in securing and maintaining adequate housing, income maintenance, general life skills, locating and maintaining employment and/or appropriate educational opportunities, and development of appropriate social/support networks to diminish tendencies towards isolation and withdrawal.

The goal of service coordination will be to enable the child and family to make maximum coordinated use of all services available to them, while minimizing duplication of services.

Integration and coordination with other providers, other payers, and other systems of care, including: CEDARR Family Centers, CASSP, Early Intervention, psychiatric hospital services, physical health care, CEDARR direct services e.g. HBTS, Early Intervention, psychiatric hospitals, school-based services, Rite Care and private health insured services, private providers (including primary care) and adult providers (MHRH,etc.), as necessary, are examples of resources which should be explored and coordinated with CIS services.

8 *Clinical Supervision*

Only a Licensed Master's clinician, who has a demonstrated competence and experience working with families and children with SED, can provide this service.

Treatment Consultation, which is a CIS Team activity, should focus on Treatment Plan implementation, response of the child and family to the therapy, approaches to understanding and addressing emerging issues in the course of treatment, and adjustment to treatment mode. Treatment consultation is intended to bring specific expertise and direction to the therapeutic regimen employed in the Treatment Plan. This service can be episodic to address particular issues or concerns, or ongoing through a child's Treatment Plan.

The following are not reimbursable:

- Agency administrative meetings;
- Telephone supervision, except in emergency situations;
- Telephone consultation, with CIS staff, except in cases of emergency;
- In person or telephone discussions relating to administrative issues;
- Transportation to and from a child's home

4.3 Continuity of Care

One of the key benefits of the CIS program is its ability and commitment to provide different levels of care as a child/family progress through treatment, while allowing for continuity of care providers. This is often critically important to maintaining stability and sustaining progress made in previous treatment. Wherever possible, and when desired by the child and family, the staff involved in their care must remain constant as they move through the different levels of care. Transition and discharge planning will make every effort to ensure continuity of care, beyond Children's Intensive Services involvement. It is critical that the provider develop with the child and family a clear service plan that is also developed in collaboration with the "receiving" agency.

4.4 Levels of Care

The level of care will determine the mix and intensity of services provided to a child and their family. There are four levels of care within Children's Intensive Services, which are: Crisis Management/Stabilization; Standard; Intermediate Care; and Maintenance. Each level contains the following categories: Admission Criteria; Risk Level; Frequency/Duration of Contact; Length of Service; Service Components; and Discharge Criteria. The four levels are listed in detail, in Attachment A.

4.5 Units and Rates of CIS Services

Reimbursement for Children's Intensive Services direct treatment service is based on an encounter structure for services provided in Attachment B. An encounter is the amount of time planned and delivered for the service; e.g., it may represent multiple hours in a day or week depending on the treatment plan, but will not consider the average number of hours for the required encounter. An encounter may be direct (i.e., face to face contact) or indirect (e.g., telephone contact, collateral contact, documentation time). The rate will be a fully inclusive team-based rate, which will take into consideration the operational costs of the program. Operational costs include expenses related to administration of the program, collateral supports, clinical staff time, supervision, psychiatric consultation, case management, transportation/travel and training/staff development time.

Reimbursements for Levels 1 and 4 are described in ATTACHMENT B

Reimbursements for Levels 2 and 3 will be on a "case rate." Please see ATTACHMENT B.

For Children's Intensive Services, four different levels of care are described within these standards (Attachment A). Reimbursement will be determined based on authorization of a specific level of care, which contains the range of hours necessary for services. The rates will vary based on the level of care provided. Authorization will be based upon the services set forth within the level of care. Monitoring will compare the necessary services, as set forth in the level of care, against the actual services delivered. Unless otherwise specified by DCYF, provider-agencies will be reimbursed only for the unit of service actually delivered each month at allowable rates.

4.6 Duration of Service

The level of care will determine the minimum/maximum authorized duration of service. Continued stay will be reviewed through the utilization management process, which will occur at a range from one-week intervals at Level 1 to one-month intervals at Level 4. Movement between levels will be determined based upon the criteria set forth in the Levels of Care. Please refer to the Levels of Care in Attachment A.

4.7 Hours of Service

The hours of service for each child and family will be dictated by the standards listed below, and will correspond to each of the four levels of care. These hours of operation are a minimum

expectation. Additional hours must be provided if indicated by the treatment plan or dictated by emergency needs. They are as follows:

Level 1-Crisis Management/Stabilization	Crisis intervention services must be available 24 hours a day, 7 days a week
Level 2- Standard	Services must be available on weekdays between 9:00AM and 7:00PM and on Saturdays as needed
Level 3- Intermediate Care	Services must be available on weekdays between 9:00AM and 7:00PM and on Saturdays as needed
Level 4-Maintenance	Services must be available on weekdays between 9:00AM and 7:00 PM

Notwithstanding the specific hours of service required for the Children's Intensive Services providers, the provider will also provide 24 hours/day, 7 days/week, 365 days/year accessibility to families, with clearly identified protocols for contact with qualified clinical staff.

4.8 Family Involvement and Responsibility

These standards identify a series of requirements for certified provider-agencies with regard to areas such as family-centered care, communication and coordination with the family. Parents have the right to refuse a CIS worker from treating their child at any time during the course of treatment.

Provider-agencies should reasonably expect that families will recognize and respect the roles and responsibilities of providers. In order for CIS to be effectively and safely provided, the family must be able to ensure that the care setting is safe and that family members will work positively with the provider-agency in maintaining a collaborative care relationship. The CIS provider-agency must guide and assist their staff in the delivery of comprehensive, coordinated family-centered care. The Provider Agency has the responsibility for creating a climate which is responsive to the child's and family's needs and supportive to its personnel. Providers must make every reasonable effort to engage family in treatment.

A critical objective of CIS is for parents to be able to safely and satisfactorily address their child's behaviors and functioning while living at home. Children and parents are to actively work with the provider in the shaping, development and implementation of the Service Plan. This child/family/provider working partnership must be clearly evident in all Treatment Plan documentation.

Upon initiation of services, families must be provided with a copy of any policies regarding suspension or discontinuation of CIS. Then, if services are provided in the home and the family does not provide an appropriate environment for care, the services may be suspended until a review of the Treatment Plan can be scheduled with the notification to the DCYF personnel.

4.9 Transportation

CIS staff may provide transportation during the course of CIS. However, the State will not assume any liability or responsibility for these activities. Any transportation provided to an outside program, facility or activity must be related to a Treatment Goal. Specific requirements for the Transportation policy are outlined in Section 6.7.1.

Provider-agencies are required to inform families of this policy and obtain the necessary documentation and parent/guardian signatures prior to providing any transportation.

4.10 Timeliness of Service Provision

The minimum time frames within which service must be made available are delineated within the levels of care description (Please refer to the levels of care table (Attachment A) for further detail. It is also required that the provider agency have an intake/screening capacity which exists independently of the levels of care and whose function it is to provide a telephonic response to referrals for Children's Intensive Services within 15 minutes. This function includes a preliminary risk assessment and triage of a case, and referral to the appropriate level of Children's Intensive Services.

In cases, which appear to require CIS Level 1, this service is responsible to alert the appropriate resources and otherwise make all reasonable efforts to assure that connection with the family is made. As Level 1 is the most intensive level of care, with the expectation of a very limited duration, services at this level must be available at all times 24 hours a day, 7 days a week, with initial contact within 15 minutes. The results of this initial Level l contact should include a psychiatric evaluation within 24 hours. . In cases, which appear to require CIS Level 2 and 3, there must be an initial telephone contact with the family within 48-72 hours of the initial referral, and depending on the nature of the response, the initial face to face contact should be within 1 day to 10 days. A full assessment and initial treatment plan must be complete within 20 days of the initial referral. The full range of services as dictated by the treatment plan must be in place within 30 days of initial referral. In cases, which appear to require CIS Level 4, these requirements only apply to re-opened cases within one year, not those transitioning from Level 2 and 3.

4.11 Provision of Authorized Services

Certified CIS provider-agencies are expected to provide the service hours within the range of the appropriate level of care. However, the State recognizes that, for various reasons, including those related to staff capacity and availability of the child and family to engage in services, CIS provider-agencies may not be able to successfully provide services for all authorized hours during a period.

Fully certified provider-agencies will be in compliance with the Certification Standard and meet performance standards. The performance standard for this Certification Standard is that a CIS provider-agency must provide 100% of authorized direct service hours to at least 90% of children and families in their caseload, within the time periods listed in the Standards. Providing less than 100% of authorized direct service hours to less than 90% of children in their caseload may result in the provider-agency receiving a provisional certification status.

5.0 CERTIFICATION STANDARDS

5.1 Requirements for Organization of Service Delivery

An applicant for certification must demonstrate that it brings to the clinical program a sound combination of clinically proven treatment approaches, clinical management, skills and experience, and the capability to reliably provide CIS. Sections 5 and 6 identify the requirements which must be addressed in a certification application.

Applicants are to describe their approach to meeting these requirements.

5.2 Agreement to Accept Eligible Referrals

Based on their clinical expertise and experience, certified CIS provider-agencies will be expected to accept all appropriate referrals of children who are determined to be eligible for CIS, and to provide services without the use of a waiting list.

5.3 Family Centeredness and Client Rights

CIS provider-agencies must incorporate key components of family-centered care into their philosophy, service program, operations and education. One resource to refer to is "Family - Centered Practice: How are we doing?" There are many more resources available for review by potential providers. Applicants must demonstrate the manner in which important principles of family-centered care are part of their approach to services.

The provider must ensure the greatest degree of family participation in the full range of CIS activity. Families must be informed of client rights, supported in their participation in Treatment Plan development, treatment modifications, and problem-resolution processes prior to the establishment of a Treatment Plan. The CIS provider-agency shall have an established approach to ensure that this communication is maintained throughout the course of care. In this regard, the provider-agency shall have established policies, procedures and related records to ensure focus on customer service, solicitation of family input, documentation of and response to complaints, and prompt complaint resolution. This means being able to address complaints from parents or recipients of CIS, as well as staff working for the agency. A parent or guardian has the right to terminate CIS at any time during an authorized course of treatment. The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral for services.

The provider-agency shall have an established approach to ensure that client rights are clearly stated and communicated. Practices shall include maintaining written policies and procedures, as well as materials provided to families at the onset of care and periodically. Written materials shall also be provided to families identifying the circumstances under which a CIS intervention will be discontinued.

5.4 DCYF- CIS Provider-Agency Dispute Resolution Process

DCYF and the provider-agency shall have established procedures to identify and resolve differences, and to demonstrate how families will be informed with respect to the following occurrences:

5.4.1 CIS Provider-Agency -DCYF CIS Provider-Agency Disagreement Process

In the event of disagreement regarding elements of the Level of Care, it is anticipated that the parties can reach resolution in most cases through joint review and discussion. Where resolution cannot be achieved, a request can be made to DCYF CBH for a final decision.

5.4.2 DCYF Fair Hearing Process

If a child's parents or guardian objects to the decision of DCYF they can request a hearing. An Administrative Fair Hearing allows for testimony to be presented from all concerned parties. In turn, the Hearing Officer renders a written decision. Upon completion of this process, the prior authorization necessary for claims to pay may be adjusted based on the hearing decision.

Rules and procedures for requesting a Fair Hearing are as follows:

1) The recipient's parents or guardian will receive written notification of the approved Level of Care following the second independent clinical review.

2) If the parents or guardian disagree with the results of the clinical review, they have ten (10) days from the date of authorization to file a request for a Hearing.

3) If a request for a fair hearing is received by DCYF within ten days, there will be no modification to the number of requested direct service hours until the conclusion of the Hearing. During this time, the provider-agency may submit claims for payment of services, as the proposed Treatment Plan in dispute remains in effect.

4) If a request is received after ten days, the approved number of direct service hours will stand until the conclusion of the Hearing. Claims will be paid in accordance with prior authorization.

5) Hearing decisions may be appealed with the Superior Court within 30 days of the date of the hearing decision pursuant to Rhode Island General Laws 42-35-1 et seq.

5.5 Strength of Program Approach: Process of Care and Management of Clinical Services

The provider of Children's Intensive Services (CIS) must demonstrate that it brings a combination of clinical experience working with children and families including psychiatric and psycho-therapeutic services (including individual, family and group counseling), case management, and therapeutic recreational services that are delivered primarily in a family and/or community setting. The provider must use levels of care in determining the process, by which treatment for children and families is to be planned, delivered monitored, and evaluated. Levels of care are included with this document as Attachment A. The Children's Intensive Services

provider must involve the child's parents or primary caregiver in the planning and design of treatment services. Involvement of child's parents, other primary caregivers and other children in the home, for children aged 18-21, will be reviewed on an individual basis. Exceptions to this will be addressed within the utilization management process.

The agency will employ staffs that have a strong base knowledge and experience in children's behavioral health, treatment of serious emotional and/or behavioral disturbances, and in child/family services. The provider will ensure that clinicians and support team staff have appropriate competencies, educational preparation and clinical experience to promote and preserve the health of children, youth and families.

5.5.1 Process of Care

Providers of Children's Intensive Services (CIS) must demonstrate that the treatment and care process is systematically organized and grounded in family centered, clinical principles and best practices for helping a child and family attain or retain the capability to function at the highest level possible within the community environment.

5.5.2 Treatment Approach and Clinical Guidelines

The Children's Intensive Services provider must demonstrate treatment approaches to effectively treat and ameliorate the challenges for children with serious emotional and/or behavioral disturbances and their families, recognizing a range of conditions impacting the children and their caregivers for which Children's Intensive Services will be provided. Clinical guidelines will permit diversity and flexibility while promoting the best possible outcome for each child. The clinical guidelines must address screening and intake, assessment and treatment planning, Treatment Plan implementation, and Treatment Plan monitoring and modification. Written standards of care, policies and procedures will be in place for all levels and aspects of CIS. The applicant must describe the treatment approach used and the range of conditions for which the treatment approach is considered to be efficacious using clinically proven interventions. DCYF reserves the right to have evidence-based information presented to support proposed clinical interventions. The applicant should clearly identify the guiding principles that govern the treatment program and their basis in empirical literature and/or nationally accepted practice standards. Sound clinical and program management are required. The applicant must provide evidence of satisfactory written and professionally recognized clinical practice guidelines along with identification of how adherence to such guidelines is systematically monitored.

5.5.3 Screening and Intake

Applicants must have an organized process for handling referrals; for screening and intake; and for determining the appropriateness of the services of this agency for a child and family. It is, at this stage, where a determination is made as to whether a child and family are appropriate for Children's Intensive Services or a lesser level of care, such as outpatient therapy. Screening and intake must be based on written policies and procedures that clearly define admission criteria and program services. These policies must ensure that contact with a family respects the family's privacy, and is conducted in a culturally sensitive and family-centered manner.

The applications for certification must include written policies and procedures for addressing the following:

- Managing referrals.
- Screening and intake.
- Eligibility and admission criteria.
- Management of direct services.
- Management of current waiting list, communication with families and with child's health insurer.
- Assisting families not eligible for CIS by providing alternative recommendations.

A documented written record of the intake is to be maintained.

5.6 Assessment and Treatment Planning

There shall be a thorough identification of the specific problem(s) to be addressed. Components of the assessment shall be identified (e.g., parent interview, child observation, conversations with school representatives, collaboration with other health care providers, and review of past evaluations). Problem behaviors should be identified with the order of importance or priority indicated by the CIS Team.

The involvement of the family and the preparedness of the family (including extended family and/or other potential caretakers) to participate in treatment shall be strongly encouraged. Unless exceptional circumstances are identified, this will include both parents even if they are not living together. All requested documentation shall be obtained solely by parental written consent and all records shall be maintained to ensure their security and confidentiality, all in compliance with appropriate Federal guidelines and laws.

As part of the assessment, licensed clinical staff should complete the Children's Global Assessment Functioning Scale (CGAS), GARF and the CAFAS.

Assessments will be detailed, comprehensive and based on established standards of clinical practices. Components of the assessment should include:

- *The child's psychiatric diagnosis* which is based upon a DSM IV multi-axial evaluation;
- *Stability of the child's condition; risk for change of his/her status; risk for this condition leading to harm to self or others; and level of risk*, all of which will be concluded through the use of the Levels of Care criteria;
- *Need for psychotropic medication*, as determined through a medication evaluation completed by a psychiatrist trained in child and family services;
- *Caregivers' understanding of child's strengths and their needs and difficulties in meeting those needs;*

- *Current stressors on child and family and supports available to them* which may be gathered through conversations with the child, other family members and involved professional collateral contacts;
- *Family's ability and willingness to engage in proposed treatment;*
- *Strengths and difficulties in child and family's interaction with the larger environment (e.g. school, legal system, peer groups);*
- *The availability and effectiveness of other service providers, systems of care and payers in supporting the child and family in treatment;*
- *Relationship with systems and providers, including delineation of how services will not be duplicative;*
- *Transition to appropriate aftercare services including formal/informal family and community supports.*

5.6.1 Diagnosis and Treatment History

The child's diagnosis (DSM IV R), current within the last year, must be clearly identified. Documentation shall identify who made the diagnosis, the basis for the diagnosis, when the diagnosis was made, and its current status. Treatment information is to be updated for any period of authorized care.

The Treatment Plan shall include information on the services that have been provided previously. Information should be present regarding any other providers that have been involved with the child and family (e.g., child psychiatrist), other treatments that have been tried or considered, and the sequence of events leading to the submission of the CIS request.

5.6.2 Treatment Plan Development and Implementation

The parent (or substitute caregiver) and, wherever appropriate, the child's signature must be on the treatment plan for services to be implemented. Treatment plans, which are based on the assessment described above, must be completed as follows:

Level 1: Crisis management plans sufficient to provide services at this level must be completed within one week, or sooner depending upon length of intervention at this level. Crisis management plans should include measurable goals and objectives geared toward moving the child to the next level of care;

Level 2 through 4: the expectation is for the Treatment, or if appropriate a revised, Treatment Plan to be completed within 10 days and full provision of services in place within 30 days (except in cases re-opened within one year)

The treatment plan will be developed with specific proposals in regard to:

- Level of care;
- Treatment/service goals and objectives, which are measurable, observable, specific and time limited-, as appropriate to the child and family/care giver-designed to enhance the child's and family's functioning within the family/caretaker environment and the larger community;
- Coordination with and participation of the family;

- Team structure and delineation of the role of each member of the treatment and supervisory structure;
- Implementation;
- Monitoring and evaluation of interventions, including family participation;
- Coordination of services with others providing services to the child and family-such as the LEA, CEDARRs, and CASSP;
- Coordination of care with health plans, for services through behavioral health benefit package;
- Expansion of capacity, where indicated, based upon collection of unmet program needs; this activity would include a service gap analysis for the System of Care to target;
- Demonstration of participation of family in assessment and treatment planning activities;
- Language used is family friendly.

Treatment plan review(s) will be conducted within the time frames set forth in the levels of care. These should consist of a review of the service goals, objectives, treatment intensity, indirect services and their subsequent effect on the child's level of functioning, as determined by Child and Adolescent Functioning Assessment Scale (CAFAS), CGAS and GARF. Reviews should be utilized, in concert with the utilization management process, to determine the appropriateness of the child's level of care.

5.6.3 Treatment Plan Modification and Renewals

The applicant must describe its procedures for Treatment Plan monitoring and modification of treatment throughout a course of care. Resources (i.e., staff and staff responsibilities) and processes (e.g., clinical supervision, treatment consultation and treatment coordination) must be identified to ensure that data is collected, analyzed, and used to inform further treatment during an approved course of CIS. It is necessary to demonstrate how data is used during clinical supervisory sessions and parent consultations to inform the delivery of care. It must also be evident that data is appropriately maintained and reviewed for determining future CIS needs. It is recognized that achieving treatment objectives will vary for many reasons. However, when treatment progress falls significantly below expectations for the provider or family, or there is evidence of regression during a course of CIS, each factor associated with an unsatisfactory outcome must be specifically addressed. Changes and modifications to treatment that result from this must also be described in detail. The provider must demonstrate that this takes place throughout a course of care.

When seeking re-authorization of CIS, it is insufficient to simply list incomplete treatment outcomes or regression as justification for CIS. The CIS provider must demonstrate how CIS can maximize the achievement of goals and improved functioning for the child and, when appropriate, the family within a specified period of time. This means reviewing methods of intervention and ensuring that best practices are followed. The latter must also address the use of other professional services (e.g., individual or family therapy, consultation with a child

psychiatrist) as well as a reexamination of treatment objectives and treatment intensity when formulating requests for services.

The CIS provider-agency must agree to provide a summary of the child's response to CIS to the child's primary care provider and other interested parties related to the child's Treatment Plan upon written request from the parent or guardian.

All reports prepared by the provider on a child receiving CIS services who is to appear before the Family Court will flow through the DCYF rather than be sent directly to the Family Court unless the Court has directed otherwise. In these cases every effort will be made to send a copy of the report to DCYF so that it will be received prior to the hearing.

5.7 Utilization Management

The utilization management process will be conducted by each provider of Children's Intensive Services, with monthly oversight and monitoring by the DCYF UR Team. The CIS supervisor, team staff, and family (including the child where appropriate) will review each treatment plan at intervals set forth within the levels of care standards. Specific goals and objectives will be reviewed and modified, as necessary. A summary of the child and family's response to the treatment plan will be developed. Recommendations may be made for a change in the level of care. Identified timelines are set as a minimum and are not intended to limit the agency's ability to respond flexibly to changes in the child's and/or family's circumstances.

The DCYF utilization and review will involve a monthly review of case data electronically transferred to DCYF by each provider. The content of the monthly data review will include the Performance Measures in Section 1.4. In addition, the DCYF will conduct on site monthly reviews by the DCYF UR Team. The purpose of this UR activity is ensure that Certification Standards are being met and to provide in a collaborative manner Technical Assistance manner to assist in the development of this newly Certified service.

5.8 Management of Clinical Services

The applicant must demonstrate a sound organizational approach to ensuring the provision of effective, timely and high quality behavioral health services. Certified providers will demonstrate that the care process is systemically organized and grounded in sound clinical principles.

In this section, the applicant will describe its clinical and administrative organization and management model for Children's Intensive Services. It is incumbent upon an applicant choosing to offer Children's Intensive Services to provide agency credentials.

5.8.1 Clinical Roles and Scope of Practice

Children's Intensive Services will be delivered through a team approach. Each CIS provider agency must have clearly identifiable job titles, and a defined organizational chart. The respective roles of team members will be based on the team supervisory structure and need to be

clearly defined through individual treatment plans. Clear description of the role of each team member is needed in such areas as:

- Supervision and job duties;
- The ways in which clinical supervision is carried out (e.g. ratio of supervisor's time to treatment team staff time);
- Staff evaluation;
- Treatment plan design/ modification, monitoring and evaluation.

The four levels of care call for varying combinations of clinical personnel. Clinical roles of team members may vary by levels of care and these variations should be detailed within the individual treatment plans.

Detailed job descriptions must be provided for each position on the clinical team, supervisory personnel must meet all applicable State licensure and certification requirements. Job descriptions will address such areas as:

- Reporting relationships, as defined with the provider's organizational chart;
- Functional tasks and performance expectations;
- Required skills, training, and experience;
- Specialized knowledge of children's behavioral health and treatment of serious emotional and/or behavioral disturbances might be indicated;
- Licensure or certification requirements;
- Successfully passed a DCYF and criminal record clearance.

5.8.2 Supervision

Clinical Supervision of CIS staff must occur throughout a period of authorized treatment. Policies and procedures must be in place to ensure the reliability and availability of supervision by qualified personnel. This means:

1. CIS supervisory staff, Licensed Masters level or above, if provided by a Psychiatrist, must have appropriate credentials and meet qualifying standards to provide supervision.

2. Written policies and procedures that demonstrate a clear supervisory structure that guides the delivery and implementation of treatment, supervision of CIS workers and management of clinical services, including assessment of progress and modifications to Treatment Plan.

3. Defining the ratio of supervisor's time to treatment team staff, showing the ways in which clinical supervision is provided.

4. Protocols identifying team meetings, team participants, and process for periodic assessment and Treatment Plan revisions as appropriate.

5.8.3 Staff Qualifications

It is the responsibility of a provider-agency to conform to DCYF requirements regarding staff credentials, training, personnel management, and practice guidelines. Staff requirements differ with respect to the role and functions associated with providing CIS. The provider-agency shall demonstrate that it meets the specific staffing requirements for all required CIS positions. The applicant must therefore give written assurances that these standards will be provided and maintained as a requirement for receiving and maintaining certification.

With respect to continuing education, the provider-agency shall have policies and procedures in place for all employees consistent with DCYF certification and licensure requirements. This requires that:

1) Licensed health care professionals providing clinical supervision and treatment consultation conform to DOH continuing education requirements according to respective disciplines. Therefore, the applicant is directed to consult with Department of Health guidelines for licensure of individual health care professionals.

2) For non-licensed clinical staff, 10 hours per year of continuing education are required from accredited programs with national or regional certifying authority. Individual staff certification to provide clinical supervision and treatment consultation must be renewed on an annual basis. Therefore, the agency must demonstrate that it can monitor and enforce this standard for employees who are subject to a variance from licensure.

A Background Criminal Investigation (BCI) and Child Abuse Neglect Tracking System (CANTS) by DCYF are required of all potential employees. The provider-agency must have policies in place to ensure that these screenings take place. In addition, the following requirements must be met for CIS employees.

5.8.3.1 Staff

Each of the four levels of care must have staff in numbers sufficient to meet the requirements of the individual treatment plans. Interventions, at each level, will be conducted utilizing a team approach. The team will be lead by, at a minimum, a licensed clinician, who has experience in the discipline of child/family therapy, in the practice of home based clinical interventions and who meets all applicable State licensure and certification requirements. The mix and intensity of staff for each intervention will be set forth within the individual treatment plan.

CIS staff will include:

Psychiatrist:
Must be Rhode Island licensed board certified, child psychiatrist;
Required to conduct psychiatric and/or medication evaluations;
Licensed Clinician:
Must be a Rhode Island licensed independent clinical social worker (LICSW), licensed marriage and family therapist (LMFT), or licensed clinical mental health worker (LCMHW) or higher;

Must have experience within child/family service;
Required for emergency hospital screenings, clinical supervision, treatment plan sign off and case management activities;
Supervision of this position will provided by the Psychiatrist.

Masters Level Clinician:

Must possess a masters' degree in social work (MSW) or related field;
Must have experience within child/family service; required for assessment and treatment plan development, home and/or community based intensive therapeutic child and family systems treatment, therapeutic case management, clinical oversight and service coordination;
Supervision of this position will be provided by the Licensed Clinician

Therapeutic Case Manager/Community Support Professional:

Must have a BA**,** or equivalent level of experience, or higher;
Must have experience with child/family service;
As part of the CIS team, this position provides required assistance and support in the development of assessment and treatment plans development, home and/or community based intensive therapeutic child and family systems treatment, therapeutic case management, and service coordination;
Supervision of this position will be provided by the Masters level team member;

Family Service Coordinator:

Must have high school diploma, or equivalent, or higher;
Must have experience with children with SED or be the immediate family member of a child with SED;
Required to assist in maintaining continuity of care, throughout the levels of care, for the child and their family;
Required to be part of the CIS Team that provides for home and/or community based intensive therapeutic child and family systems treatment, therapeutic case management, and service coordination;
Supervision of this position will be provided by the Case Manager or the Masters Level Clinician.

CIS staff may include:

Psychologist:

Must be Rhode Island licensed or have a Masters degree
Must have two years experience with child/family service;
Must meet all applicable State licensure and certification requirements

Registered Nurse/Clinical Nurse Practitioner/Clinical Nurse Specialist :

Must be Rhode Island board licensed ;
Must have experience with child/family service;

5.8.3.2 Training

All staff shall be provided with a general orientation to the provider-agency with respect to its mission, policies and procedures, administrative structure, training, and other relevant information. The provider-agency must have policies and programs for orientation, training of

new staff, and for continuing education and professional development that fully meet the Certification Standards. Staff is required to participate in these activities, as specified by the Individual's position and job description.

Personnel files shall contain documentation of the training programs staff has completed. Provider-agencies must have a written program for in-service training and orientation of all new employees. Provider-agencies shall annually determine staff training needs and develop a written plan and schedule of staff training.

The provider-agency shall delineate the requirements used to ensure that all CIS team members are fully qualified to implement all aspects of a Treatment Plan before engaging in the delivery of care to a family. As a condition of employment and on a case-by- case basis, home-based staff shall have basic knowledge and skills. The provider-agency shall demonstrate its required basic training for all CIS workers.

Providers of Children's Intensive Services programs are required to ensure that staff attend scheduled trainings and workshops specifically designed for enhancing staff understanding and competencies regarding best practices in treatment and care of children with serious emotional disturbances and their families. The provider-agency shall demonstrate its required basic training for all CIS workers. It is recommended that basic training for all CIS workers shall include, but not be limited to the following:

- Service Coordination for Mental Health Care Providers, Parents, and Educators provide a core curriculum for competency and skill-based training four times annually. Training includes such topics as:
    - Orientation/Team Development
    - System Overview
    - Family Systems
    - Cultural Diversity
    - Working in Partnership with Families (family centered interventions)
    - Communication in the Face of Conflict
    - Recognizing and Responding to High Risk Situations (abuse and neglect)
    - Recognizing and Responding to High Risk Situations (suicide and violence)
    - Children's Mental Health
    - Legal and Client Rights/Closure
    - Substance Abuse
    - Domestic Violence/Violence/Aggression

  Additional training opportunities for CIS providers may include:
    - Multi-Axial Training on DSM-IV Assessments
    - Family and Child Therapeutic Approaches
    - Use of Restraint
    - Crisis Intervention - Techniques appropriate to child behavior/ages, etc.
    - Working with Substance Abusing Parents/Children
    - Parent/Child Attachment

- Parent/Child Interaction
- Parent/Youth Conflict
- CASSP/Local Coordinating Council Systems Functioning
- CEDARR System Functioning
- LEA System Functioning
- Children's Global Assessment Scale (CGAS)
- Global Assessment of Relational Functioning scale (GARF)
- Child and Adolescent Functioning Assessment Scale (CAFAS)
- CGAS and CFAS inter-ratered reliability

5.9 Record Keeping Requirements

The provider-agency must describe its policies and procedures for record keeping. Systematic recording of CIS hours provided on a weekly basis with family verification is required. For the CIS worker, time sheets documenting the specific hours of service provided per shift must be co-signed weekly by their supervisor weekly. Families must sign off on the Treatment Plan at inception and review. Parental signatures will be viewed by DCYF as a crucial part of the service record. Services billed shall correspond to the approved hours requested and delivered in accordance with the Treatment Plan and be supported by written documentation. The provider-agency must describe its policies and procedures for record keeping. The provider-agency must ensure family access to the clinical record and that patient confidentiality is maintained. Additionally, the agency must provide long-term storage of clinical records in accordance with Medicaid regulations.

The client case record shall include:

- Client referral sheet
- Date of initial intake phone contact with provider program
- Date and time of initial phone contact with Children's Intensive Services staff
- Date of initial face to face contact with child and family by CIS staff
- Assessment with supporting documentation materials
- Individual treatment plan with measurable goals and objectives
- Narrative description of encounters with child and their family, and collateral service providers, including progress on treatment plan goals and objectives
- Utilization management documentation
- Discharge plan
- Outcome Measures/CAFAS and CGAS

DCYF may also request additional reports, documentation, and site visits, as necessary to monitor compliance with these Certification Standards and services provided by the provider-agency.

5.10 Service Monitoring and Reporting

Monthly:

Children's Intensive Services providers will maintain an information system, which will allow them to effectively monitor and manage Children's Intensive Services. Providers will be required to provide monthly reports to DCYF in the format established by DCYF. State reporting requirements are established to track routine compliance with certification standards and should relate to elements of operations, which would be tracked as part of standard operations. Monthly reports will include the following:

- Total caseload of children served during the month (unduplicated)
- Number of new cases during month
- Number of closed cases during month
- Number of extensions of service, beyond initial treatment plan goal, during month approved
- Number of extensions of service, beyond initial treatment plan goal, during the month denied
- Number of psychiatric hospitalizations
- Number of psychiatric re-hospitalizations

For new cases:

- Date of admission
- Date of initial contact
- CGAS , CAFAS and GARF score at entry
- City/Town where child resides at entry

For closed cases:

- Date of discharge
- Reason for discharge (based upon DCYF created list)
- Where did child and family transition to (type of program; level of care?)
- CGAS, CAFAS and GARF score at discharge

Aggregate hours of service provided, broken down by level of care
Numbers of children and family moving down the Levels of Care
Numbers of children and families moving up the Levels of Care
Numbers of DCYF children and families
Numbers of non- DCYF children and families

Quarterly:

1. Number of unduplicated children served:

    - age;
    - primary language spoken in home;
    - race/ethnicity.
    - gender
    - city/town
    - level of care
    - diagnosis
    - length of stay
    - current CGAS score

- current CAFAS score
- mean hours of service per week
- mean hours of service per week, by primary diagnosis
- number of children discharged;
- number of children by discharge reason;
- number of children discharged to lower level of care;
- number of children discharged to higher level of care;
- number of DCYF children;
- number of non-DCYF children;

2. Rate of recidivism;
3. Services for other family members;
4. Total FTE of CIS program staff (quarterly basis);

5. Number of staff (quarterly report) by:
   - gender
   - linguistic skills
   - race/ethnicity
   - job classification
   - Number of staff turnover, by
   - Job classification
   - Employment end reason- if appropriate to ask
   - Targeted hours for in service training

These measures will serve as a complement to the service information being requested, on a quarterly basis, which are detailed in Section 5.10.

5.11 Cultural Competency

The program must provide services in the most culturally competent manner possible. The CIS provider agency should work toward these standards as a goal. DCYF will work with provider agencies to conduct periodic needs assessment and analysis, based upon CIS caseload, in regard to the provision of culturally competent services. This includes, but is not limited to:

Language: It is expected that the provider have staff to conduct assessment, treatment planning and direct services in the native language of clients. If this is not possible, services must be offered through the utilization of a qualified interpreter other than a member of the client's family.
Staff: It is a goal of the CIS program that, dependent upon the family's desire , at least one member of each service team working with a family has a member who can be identified as a member of the ethnic/cultural minority group that is representative of the family's ethnic/cultural group.
Training, education, experience: Programs are expected to assess the ability of all direct and supervisory staff to do effective work with families of all ethnic/cultural/language groups on

their caseload. Based on these individualized assessments, programs are required to provide training and consultation to all staff to enhance their capacity for culturally competent work.

5.12 QUALIFIED ENTITY

A certified provider must be able to demonstrate that it complies with core State requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance improvement and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

Applicants for certification are not required to systematically address in detail each of these areas in their certification applications. Rather, these are set forth as fundamental requirements for certified entities. In many areas applicants will be asked to provide assurances that their agency systematically addresses each of the standards identified. In certain areas, more specific description regarding the manner in which the agency meets the standard is required. The Application Guide provides guidance as to how the application should be structured and the areas, which need to be addressed.

In not requiring applicants to explicitly address the elements in Section 6, the State is seeking to simplify the effort needed to develop an application; these certification requirements remain in place. The State reserves the right to review certified entities for compliance with these certification requirements.

5.13 Incorporation and Accountable Entity

The applicant for certification as a Children's Intensive Services provider-agency must be legally incorporated and have the ability to bill RI Medicaid for services provided. The certified entity shall serve as the accountable entity responsible for meeting all of the terms and conditions for providing CIS. Applicants must clearly present the overall structure by which services, requirements and programmatic goals will be met. The corporate structure of the entity must be clearly delineated.

5.14 Partnership or Collaboration

Satisfactory performance as a certified CIS provider-agency calls for significant organizational capability. In some cases this capability may be present within a single organization and application for certification will be made based on the strengths of that single organization. In other cases the application may represent the joint effort of several parties, which have the combined capabilities to meet the certification requirements. This could come, for example, through a joint venture, a formal partnership or an integrated series of executed contractual arrangements. Regardless of form, a single legal entity will be certified with overall responsibility for performance. The certified CIS provider-agency is to be the single billing agent for all CIS following the RI Medicaid protocols.

5.15 Governance and Mission

The governance of the entity must be clearly delineated. Composition of the Board of Directors and any conditions for membership must be clear. The overall performance of an organization flows from the philosophy and oversight of the leadership. Leadership and stakeholders "build" the mission, vision and goals; this in turn shapes the business behavior and is reflected in the tone that leadership sets for the operation of the organization. The leadership strives to recruit members who reflect the cultures and ethnic backgrounds of clients, and to provide a mix of competencies that address organizational needs. Specific standards regarding governance and mission are as follows;

1) The agency has a clearly stated mission and publicly stated values and goals.
2) The agency is operated/overseen by some type of legally or officially established governing body, with a set of governing documents or by laws. This governing body has full authority and responsibility for the operation of the organization.
3) The governing body is self-perpetuating and has a recruitment and periodic replacement process for members to assure continuity and accountability.
4) The governing body hires, supervises, and collaborates with a chief executive officer or director. Together the executive and governing bodies provide organizational leadership.
5) The governing body has final accountability for all programs. Through a collaborative relationship with the executive and the management team, the governing body is responsible for developing the program goals and mission and ensuring compliance with legal and regulatory requirements.

5.16 Well Integrated and Organized Management and Operating Structure

The CIS provider-agency will be able to function in an efficient and effective manner, assuring consistency and quality in performance and responsiveness to the needs of families. The applicant shall provide clear identification of who is accountable for the performance of CIS. This includes administration, clinical program quality, and management of service delivery and overall financial management.

5.17 Administration

Specific standards regarding administration are as follows:

1) The Executive Director under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.
2) A current chart of organization, which clearly defines lines of authority within the organization, must be maintained and provided as part of the certification application.
3) The management of the organization is involved in the planning process for performance improvement and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement plan.
4) There is a written corporate compliance plan in place that is adopted by the governing body.

5.18 Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to clients. Fiscal management is conducted in a way that supports the organization's mission, values, and goals and objectives in accordance with responsible business practices and regulatory requirements. Financial management requires a set of sophisticated financial planning and management capabilities if the organization is to remain viable. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes. Specific standards regarding financial systems are as follows:

1) Financial Management is provided by a Chief Financial Officer, Fiscal Director, or Manager with demonstrated experience and expertise in managing the finances of a human services organization with third party reimbursement. In larger organizations (e.g. with revenues in excess of $1 million) this might be an MBA with demonstrated finance experience or a CPA; in smaller organizations a comptroller with a degree in accounting might be sufficient. This individual must possess expertise in financial and client/patient accounting, financial planning and management.
2) The organization's financial practices are consistent with the most up to date accounting methods and comply with all regulatory requirements.
3) The organization's financial planning process includes annual budgeting, revenue projections, regular utilization and revenue/expense reports, billing audits, annual financial audits by an independent CPA, and planning to ensure financial solvency.
4) The organization has written policies and procedures that guide the financial management activities (including written policies for and procedures for expenditures, billing, cash control; general ledger, billing system; registration/intake system; payroll system; accounts payable; charge and encounter reporting system and accounting administration).
5) The organization has evidence of internal fiscal control activities, including, but not limited to cash-flow analysis, review of billing and coding activities.
6) The system must track utilization of service units separately for each individual client and aggregate this information by payer, performing provider and diagnosis/problem.
7) The organization has a billing office/function that bills for services rendered and collects fees for service and reimbursement.
8) The organization assesses potential and actual risks, identifies exposures, and responds to these with preventive measures.
9) The organization carries appropriate general liability insurance, and ensures that appropriate professional liability policies are maintained for program personnel.
10) Where the organization contracts with outside entities and/or providers, policies and procedures mandate contract language to detail the entity's or provider's accountability to the Governing Body and its By-laws.

11) The organization has systems that facilitate timely and accurate billing of fee-for-service, capitated, and case-rated insurance plans, clients and other funding sources. Once bills are forwarded to payers, the system properly manages payments, follow-up billing, collection efforts and write-offs.
12) The organization has a written credit and collections manual with policies and procedures that describes the rules governing client and third-party billing. Specifically, the organization has in place and adheres to policies and procedures ensuring compliance with Medicaid regulations pertaining to coordination of benefits and third party liability. Medicaid by statue and regulation is secondary payer to all other insurance coverage.
13) Clinical, billing and reception/intake staff receives ongoing training and updates regarding new and changed billing and collection rules and regulations.

5.19 Human Resources, Staffing

Human Resource activities within the organization are conducted to ensure that proper staffing for optimum service delivery to clients occurs through hiring, training, and oversight of staff activities. The activities are organized to serve the governing principles of the organization and compliance with these Certification Standards. The organization provides clear information to employees about job requirements and performance expectations, and supports continuing education, both internal and external, that is relevant to the job requirements of the individual. In addition, all staff receive training about major new organizational initiatives and about key issues that may affect the organization overall.

Specific standards regarding Human Resources and Staffing are as follows:

1) The organization's personnel practices contribute to the effective performance of staff by hiring sufficient and qualified individuals who are culturally and linguistically competent to perform clearly defined jobs.
2) Employee personnel records are kept that contain a checklist tickler system to track appropriate training, credentialing and other activities. A copy of each employee's active license will be kept on file.
3) The provider-agency must perform annual written performance appraisals of staff based on input from families and supervisors. These must be available in the personnel files for review by DCYF upon request.
4) Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
5) Staff is hired that match the requirements set forth in both the appropriate job description and in the policies and procedures.
6) Each employee's record contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. Supervisory job descriptions establish expectations for both contributing to the organization's goal attainment and for communicating the goals and values of the organization. All job descriptions include standards of expected performance.
7) The organization provides a clear supervisory structure that includes plainly delineated spans of control and caseloads as appropriate. The roles of team members are defined with a clear

scope of practice for each. Supervisors receive specialized training and coaching to develop their capacities to function as managers and experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision.
This includes:

a) Protocols for communication and coordination with all interested parties (e.g., special education, primary care physician, or other specialists).

b) Clear procedures for addressing unmet licensure requirements will be stated. Credentialing records will be maintained annually to document compliance.

8) Credentials of staff established by the management team and approved by the Governing Body are contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, as appropriate, and records maintained in the employee's record.
9) A record of primary source verification is maintained in the individual employee record.
This includes, at a minimum, verification of licensure, review of insurance coverage liability claims history, verification of board certification for physicians, verification of education and training required by law, and professional references and performance evaluations about applicant's ability to perform requested duties. The individual employee record for behavioral health practitioners should also contain a signed statement from the practitioner that addresses if any Medicare or Medicaid sanctions have been imposed in the most recent three-year period.
10) Staff has appropriate credentials and meets qualifying standards of the organization. These are updated and checked regularly.
11) The organization provides training and training opportunities for all levels of staff.
12) Staff is required to participate in training activities on an ongoing basis, as specified by the organization and position and job descriptions.

5.20 Quality Assurance/Performance Improvement

The organization is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement plan). The organization ensures that information is collected and used to improve the overall quality of service and performance of the program. The Quality Assurance/Performance Improvement (QA/PI) program that the organization develops strives to: improve the systems related to the delivery of service to the clients; include the preferences of clients in the provision of services; and measure the process and outcomes of the program services. The QA/PI program is an ongoing process of planning, monitoring, evaluating, and improving the system in order to improve the outcomes of service provided to clients.

Standards regarding Quality Assurance/Performance Improvement are as follows:

1) The organization has a Quality Assurance/Performance Improvement program that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records review and operational/systems improvement. Written records are maintained for PI program activities.
2) The QA/PI program contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.

3) Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes.

5.21 Information Management, Record Keeping

The organization must use data to affect the performance, stability, and quality of the services it provides to clients, in its governance, and other systems and processes.

Standards regarding information management and record keeping are as follows:

1) The organization obtains, manages, and uses information to enhance and improve its performance. Information it maintains is timely, accurate, and easily accessible, whether maintained in electronic or other format. Evidence exists that information gathered and maintained is used in decision-making for the organization.
2) The organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.
3) The organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements when such standards are promulgated and effective.
4) The information management plan specifies standard forms and types of data collected for client intake, admission, assessment, referral, services, and discharge.
5) The information management plan has an incident reporting and client grievance-reporting component.
6) Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.

a) The organization maintains signed releases for sharing of clinical information.

b) Where necessary, signed affiliation agreements exist.

c) Reports are available on an appropriate schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, case managers, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress.

d) Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis.

7) The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure.

a) The organization has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.

b) Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.

8) Client information is accessible and is maintained in a consistent and timely manner, with enough information to support the consumer's needs or diagnosis, to justify services delivered, and to document a course of treatment and service outcomes.

a) Every client will have a record that contains: an initial assessment, the detailed assessment of client assets and needs, client goals care/Treatment Plan, documentation of care/services provided, documentation of change in client's status, and where necessary, discharge summary.

b) All records must include evidence of informed consent, where required.

9) The client record documents treatments/interventions provided and results from the treatments/interventions. All entries into the client records are dated and authenticated, and follow established policies and procedures.

a) Changes in client's condition or lack of change following service provision are recorded in the client record at the time of service provision and signed by the service provider.

b) Achievement of a client objective or milestone toward an objective is noted in the client record. Achievement of an objective or milestone results in a revised assessment.

c) Lack of progress in achieving a client objective or milestone toward objective results in a reassessment of the client.

10) The client record will be the basis for billing. All service billings must be substantiated in the client record.

5.23 Health and Safety, Risk Management

The organization supports an environment that promotes optimal safety and reduces un-necessary risk for clients, family members and staff. The nature of CIS calls for specific policies and procedures to assure that services are provided in a safe and effective manner for both the child and the staff.

Standards regarding Health, Safety, and Risk Management are as follows:

1) The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement program committee and the Governing Body.
2) The organization will have protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.
3) Health and safety policies and procedures are clearly communicated to agency staff, visitors, and clients.
4) Programs will have an effective incident review process.

5.24 Transportation

In the course of provision of services the provider-agency may want to provide transportation if clinically relevant. The State is approving only the service provision and accepts no liability or responsibility for transportation. Transportation can only relate to the child/family receiving CIS. Inclusion of transportation as part a Treatment Plan is only appropriate if it clearly relates to facilitating the accomplishment of defined and previously approved treatment objectives.

The provider-agency must demonstrate that it has procedures in place to protect the safety of child being transported. This means addressing certain minimum criteria for all staff and vehicles engaged in transportation:

1) Current and appropriate vehicle insurance that allows for transporting children.
2) Current vehicle registration and valid State inspection.
3) The driver's history should be free of accidents for the past year, with no history of DWI.
4) Parents have signed a waiver for each driver releasing the State of any liability and responsibility for anything that occurs as a result of transportation activities.

September 1, 2003, Attachment A, Children's Intensive Services- Levels of Care

Children's Intensive Services (CIS) - *Admission Criteria*

Eligibility for Children's Intensive Services (CIS) for all levels must be based on the child's having a **DSM (current edition) Axis I or Axis II diagnosis and a major functional impairment** (*defined as a substantial interference with or limitation of a child's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills*), **which has lasted or is expected to last at least one year; and child is at risk for out-of-home placement or placement in a more restrictive setting (due to presenting concerns with behavior).** and based on the following: a DSM (current edition) multi-axial evaluation with an Axis I or Axis II diagnosis and an Axis V score based on the Children's Global Assessment Scale (CGAS) identified within the levels of care **and meet criteria for Serious Emotional Disturbance (SED),** as defined in RIGL 42-72-5(b)(24)(v); or in the Individuals with Disabilities Education Act (IDEA), 34CFR300.7(c)(4).

Level 1 - High Risk Crisis Management/Stabilization	*Level 2* -Moderate Risk Standard	*Level 3* - Moderate/Mild Risk Intermediate Care	*Level 4* - Mild/Minimal Risk Maintenance
➢Children may enter through each provider's intake/screening process as a new CIS intervention, or may transition from a less intensive level of care as an ongoing CIS intervention ➢Child or family is experiencing a behavioral; psychiatric; and/or developmental crisis that threatens the child's ability to remain in or move to a less restrictive living environment. ➢The episode and response may be: ♦ within the context of current CIS involvement by the child/family; or ♦ initial contact with a child/family, not previously known to the Provider ➢The Children's Global Assessment Functioning scale (CGAS) score is between 10 and 30. ➢Child has a major impairment in functioning in several areas and is unable to function in almost all areas (e.g. home, school, peer interaction) ➢The family agrees to cooperate and work with the in-home stabilization team	➢Child/family service need has been reassessed from a more or less intensive level of care; or ➢Child/family has multiple needs, for which other less intensive levels of service have not been effective;(e.g. outpatient) ➢The Children's Global Assessment Functioning scale (CGAS) score is between 31 and 40 ➢Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools, such as CBCL or CGAS, must be applied during treatment plan review and utilization review to determine level of need ➢Child/family is able to tolerate and function at this level	➢Child/family has transitioned from a more intensive or less intensive level of care ➢The Children's Global Assessment Functioning scale (CGAS) score is between 41 and 50 ➢Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools, such as CBCL or CGAS, must be applied during treatment plan review and utilization review to determine level of need ➢Child has variable functioning with sporadic difficulties or symptoms in several but not all psychosocial areas ➢Child/family has multiple needs, which are unable to be addressed through a single service (i.e. outpatient) ➢Child/family has identifiable and available useful supports in community ➢Child/family is able to tolerate and function at this level of intensity	➢Child/family has transitioned from a higher level of care, or has had a prior CIS intervention ➢There will be no direct entry to this level, except in cases of CIS intervention that have closed within the previous 12 months (as deemed appropriate) ➢The Children's Global Assessment Functioning scale (CGAS) score is between 51 and 60 ➢Child has some difficulty in a single area, but is generally functioning well ➢Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools, such as CBCL or CGAS, must be applied to determine level of need ➢Child/family is able to tolerate and function at this level

ADMISSION CRITERIA

Children's Intensive Services (CIS) - *Risk Criteria*

Risk to child has been determined by the Risk Assessment Guide and the Children's Global Assessment Functioning (CGAS) scale

Level 1 **Crisis Management/Stabilization**	*Level 2* **Standard**	*Level 3* **Intermediate Care**	*Level 4* **Maintenance**
Very High Risk: in crisis ➢Crisis requires behavioral health intervention and assessment to ensure safety of child/family ➢Actual or potential danger is such as to present immediate risk to the child/family, or to others in contact with the child/family **High to Moderate Risk: in stabilization** ➢Child is exhibiting behavior, expressing thoughts or presenting with impaired judgment, that make it possible that harm will occur, but there is no immediate risk of violence or self-harm ➢Situation is not imminently life threatening. Child, or other family member, expresses thoughts of dangerous ideation but denies intent to follow through ➢Child, or other family member, is actively psychotic with potential for violence but has no history of overt violent acts	**Moderate risk** ➢Child, or other family member, has moderate to severe psychiatric symptoms and is experiencing moderate to severe psychosocial stressors ➢Child, or other family member, has depressive symptoms and increase in psychosocial stressors ➢Psychiatric symptoms may be stable and there is no presence of suicidality or self harming behavior ➢Child/family has limited social support and self-support network is under significant stress ➢Child/family exhibits poor coping skills ➢Parent with chronic mental illness and/or cognitive limitations	**Mild to Moderate risk** ➢Child, or other family member, has moderate psychiatric symptoms and is experiencing moderate psychosocial stressors ➢Child, or other family member, has mild depressive symptoms and moderate psychosocial stressors ➢Mild risk of danger ➢Psychiatric symptoms may be stable and there is no presence of suicidality or self harming behavior ➢Child/family exhibits poor coping skills ➢Child/family has identified social support network and self-support network is under moderate stress	**Mild to Minimal risk** ➢Situation does not present any physical danger or risk ➢Child, or other family member, is having mild psychiatric symptoms ➢Child/family has identified social support network and self-support network is under mild stress ➢Risk for regression to higher level of need if essential services are not provided at this level

RISK CRITERIA

Children's Intensive Services (CIS) - *Frequency and Duration*

Level 1 **Crisis Management/Stabilization**	*Level 2* **Standard**	*Level 3* **Intermediate Care**	*Level 4* **Maintenance**
During Crisis Intervention ➢24 hour face-to-face emergency crisis intervention services must be available as needed, with a minimum of telephone contact within ½ hour of presentation of crisis and face to face contact within 2 hours of presentation of crisis ➢Intense staff participation (direct with family and indirect with collaterals and team), within a 24 hour period ➢A crisis management plan will be developed within 24 hours of initial contact. Plan is made with family and includes strategies for dealing with escalated crisis over the next 24 hours. ➢**During Stabilization Intervention** ➢6 - 14 hours per week of direct, intensive contact with child, family and/or primary caregivers, ➢The team includes clinician and case mgt./collateral support with psychiatrist/clinical nurse practitioner time available to consult with the team, as needed	➢This level will provide flexible hours of service provided by a team ranging between 2 to 10 hours per week, depending on whether there are multiple children in home who are also receiving CIS services, or whether services are tailored to a single child. ➢In cases with multiple children, a supervising/ coordinating clinician will oversee case activity and treatment plans. ➢The team includes clinician, case management and family service coordinator. ➢Psychiatrist/ clinical nurse practitioner time for consultation to the team for all of their cases, as needed.	➢This level will provide flexible hours of service provided by a team ranging between 2 to 5 hours per week, depending on whether there are multiple children in home who are also receiving CIS services, or whether services are tailored to a single child. ➢This service extends the continuity of care in CIS for child, ,needing individual, group, or family therapy ➢This service serves as a liaison to other community based systems, in order to continue the child's transition to less intensive levels of care ➢The team includes clinician, case management and family service coordinator. ➢Psychiatrist/ clinical nurse practitioner time for consultation to the team for all of their cases, as needed.	➢This level will provide flexible hours of service provided by a team, of 30 minutes per week ➢This service provides outreach and follow-up services for longer term involvement and support. ➢Expectation is 2 hours per month of case management/ collateral support ➢The team includes clinician, case management and family service coordinator. ➢Psychiatrist/ clinical nurse practitioner time for consultation to the team for all of their cases, as needed.

FREQUENCY AND DURATION

Children's Intensive Services (CIS) - *Length of Service*

Level 1 **Crisis Management/Stabilization**	***Level 2*** **Standard**	***Level 3*** **Intermediate Care**	***Level 4*** **Maintenance**
➢ Sustained involvement and transition to less intensive treatment should last no more than two weeks (14 days) ➢ Through the utilization management process, if the child/family no longer meets admission criteria for this level of care, a reassessment of the appropriate level of care is required. ➢ The utilization management process will occur at the end of the first week of the two week service period, or at discharge, if sooner than one week and must be documented in the child/family record	➢ Length of stay will last from 1 to 3 months ➢ Reviews of treatment plan will occur at 1 month intervals, or at discharge if sooner ➢ Treatment plan review(s) should consist of a review of the service goals, objectives, treatment intensity, indirect services and their subsequent effect on the child's level of functioning, as determined by Children's Global Assessment Functioning (CGAS) Scale, Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools. ➢ Through the utilization management process, if the child/family no longer meets admission criteria, a reassessment of the appropriate level of care is required. The utilization management process will occur at each 2 week interval, throughout the duration of the service, and must be documented in the child/family record ➢ Continued stay may be appropriate (as determined through treatment plan review) based upon the following criteria: ➢ child/family continues to meet admission criteria for this level of care and less intensive care is not appropriate ➢ individualized treatment plan reflects a change in progress ➢ For children aged 18 to 21 who may be eligible for adult mental health services, transition to those services will be initiated.	➢ Length of stay will last from 3 to 6 months ➢ Reviews of treatment plan will occur at 1 month intervals, or at discharge if sooner ➢ Treatment plan review(s) should consist of a review of the service goals, objectives, treatment intensity, indirect services and their subsequent effect on the child's level of functioning, as determined by Children's Global Assessment Functioning (CGAS) Scale, Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools. ➢ Through the utilization management process, if the child/family no longer meets admission criteria for this level of care, a reassessment of the appropriate level of care is required. The utilization management process will occur at each 4 week interval, throughout the duration of the service where continued stay has been deemed appropriate, and must be documented in the child/family record ➢ Continued stay may be appropriate (as determined through treatment plan review) based upon the following criteria: ➢ child/family continues to meet admission criteria for this level of care and less intensive care is not appropriate ➢ individualized treatment plan reflects a change in progress ➢ For children aged 18 to 21 who may be eligible for adult mental health services, transition to those services will be initiated	➢ Length of stay may last for up to six months ➢ This level of care is intended to maintain the stability achieved at higher levels of CIS care. ➢ The utilization management process will initially occur at 4 weeks, and will continue at each 1 month interval, throughout the duration of the service, where continued stay is appropriate ➢ Reviews of treatment plan will occur at 1 month intervals, or at discharge if sooner ➢ Treatment plan review(s) should consist of a review of the service goals, objectives, treatment intensity, indirect services and their subsequent effect on the child's level of functioning, as determined by Children's Global Assessment Functioning (CGAS) Scale, Child and Adolescent Functioning Assessment Scale (CAFAS), or other norm referenced tools. ➢ If the child/family no longer meets admission criteria for CIS level services, a reassessment of the appropriate level of care, through the utilization management process, is required. ➢ Continued stay may be appropriate (as determined through the utilization management process) based upon the following criteria: ➢ child/family continues to meet admission criteria for this level of care and traditional outpatient service is not appropriate ➢ For children aged 18 to 21 who may be eligible for adult mental health services, transition to those services will be initiated.

LENGTH OF SERVICE

Children's Intensive Services (CIS) - *Service Components*

Level 1 **Crisis Management/Stabilization**	*Level 2* **Standard**	*Level 3* **Intermediate Care**	*Level 4* **Maintenance**
In Crisis Management ➢ Services, at this level, should be provided at least 85% of the time by a clinical practitioner. If services fall below this level the child should be transitioned to a less intensive level of care ➢ The level and nature of the crisis will be assessed and a crisis management plan will be developed ➢ Available family supports will be identified and mobilized, as part of the crisis management plan **In Stabilization** ➢ The following services will be provided and coordinated, as needed: ◊ Crisis Stabilization ◊ Crisis Assessment and Intervention ◊ Crisis intervention/ assessment ◊ Medication evaluation ◊ Therapeutic case management, with clinical oversight by the licensed team lead (masters' level or higher clinician) ➢ Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g.,hospital, school, foster home, group home, office)	➢ Services, at this level, should be provided at least 80% of the time by a clinical practitioner. If services fall below this level , the child should be transitioned to a less intensive level of care ➢ The following services will be provided and coordinated : ◊ Comprehensive Family Assessment and/or Reassessment, in which level and maturity of child, and functioning as a whole, will be assessed ◊ Development of a detailed, individualized treatment plan with the family ◊ Home and/or community based intensive therapeutic child and family systems treatment as prescribed by the clinical treatment plan from a masters' level or higher clinician trained in this discipline ◊ Therapeutic case management, with clinical oversight by the team lead (masters' level or higher clinician) ◊ Service coordination including: ◊ coordination of any educational and medical needs ◊ therapeutic support services ◊ coordination with additional support systems, i.e. CASSP, CEDARRS ➢ Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g.,. office, school, foster home, group home)	➢ Services, at this level, should be provided at least 60% of the time by a clinical practitioner. If services fall below this level , the child should be transitioned to a less intensive level of care ➢ The following services will be provided and coordinated: ◊ Comprehensive Family Assessment and/or Reassessment, in which level and maturity of child, and functioning as a whole, will be assessed ◊ Development of a detailed, individualized treatment plan ◊ Home and/or community based intensive therapeutic treatment, with the family, as prescribed by the clinical treatment plan from a masters' level or higher clinician trained in this discipline ◊ Therapeutic case management, with clinical oversight by the team lead (masters' level or higher clinician) ◊ Service coordination including: ◊ coordination of any educational and medical needs ◊ therapeutic support services ◊ coordination with additional support systems, i.e. CASSP, CEDARRS ➢ Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g. . office, school, foster home)	➢ The following services will be provided and coordinated: ◊ Comprehensive Family Assessment and/or Reassessment, in which level and maturity of child, and functioning as a whole, will be assessed ◊ Development of a detailed, individualized treatment plan ◊ Home and/or community based intensive therapeutic treatment as prescribed by the clinical treatment plan from a masters' level or higher clinician trained in this discipline ◊ Therapeutic case management, with clinical oversight by the team lead (masters' level or higher clinician) ◊ Service coordination including: ◊ coordination of any educational and medical needs ◊ therapeutic support services ➢ coordination with additional support systems, i.e. CASSP, CEDARRS**,** in order to be mindful of the need to transition the child/family to a less intensive level of care ➢ Unless clinically contraindicated and as prescribed by the treatment plan, services will be provided in the home of the primary client or in the community e.g. . office, school, foster home)

SERVICE COMPONENTS

Children's Intensive Services (CIS) - *Discharge Criteria (Any of the following are suitable)*

Level 1 **Crisis Management/Stabilization**	*Level 2* **Standard**	*Level 3* **Intermediate Care**	*Level 4* **Maintenance**
➢ Child/family no longer meets admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care ➢ Child and family crisis management plan goals have been met ➢ Child and family able to function at less intensive level ➢ Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity	➢ Child/family no longer meets admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care ➢ Child and family treatment plan goals have been met ➢ Child and family able to function at less intensive level ➢ Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity	➢ Child/family no longer meets admission criteria and a reassessment of the appropriate level of care requires a higher or less intensive level of care ➢ Child and family treatment plan goals have been met ➢ Child and family able to function at less intensive level ➢ Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity	➢ Child/family no longer meets admission criteria for this level ➢ A reassessment of the appropriate level of care requires a higher or less intensive level of care ➢ Child/family is referred to outpatient counseling services or other less intensive level of care ➢ Child and family treatment plan goals have been met ➢ Child and family refuse treatment and clinical risk does not require involuntary action by Provider or Rhode Island governmental entity

DISCHARGE CRITERIA

ATTACHMENT B

Children's Intensive Services
New Rates, Effective upon Certification

Level	DURATION (WEEKS)	Hours per Week	Maximum Units	Rate
I	2	10	20	$100.00 per hour (15-minute increments)
II **Provisional Certification**	8	7	56	$135.00 per diem $114.75 per diem
III **Provisional Certification**	12	3.5	84	$75.00 per diem $63.75 per diem
IV	8	0.5	16	$17.50 per encounter (15 minutes)

ATTACHMENT C

Application Guidelines

September 1, 2003

Instructions for Applicants:

A. Before you Begin

- After reviewing the Certification Standards, make sure your proposal responds to all sections.

B. Preparing your Proposal

- Be thorough in your program narrative. Write so that someone who knows nothing about your organization or your program can understand your proposal.
- Make sure your budget narrative provides enough detail so the Reviewers are able to clearly evaluate the link between the proposal's program narrative and the CIS Rate Structure, Attachment B.
- Organize your proposal following the detailed listing of Certification Standards as found in Section 5. These certification standards will be the basis on which your proposal will be reviewed and scored. These Standards are:

  AGREEMENT TO ACCEPT ELIGIBLE REFERRALS.

  FAMILY CENTEREDNESS AND CLIENTS RIGHTS.

  DISPUTE RESOLUTION PROCESS.

  STRENGTH OF PROGRAM APPROACH: CARE AND MANAGEMENT OF CLINICAL SERVICES.

  QUALIFIED ENTITY.

- The proposal should be no more than twenty five (25) double spaced, single sided pages. This page limit does not apply to any appendices you may want to submit.

C. Submitting your Proposal

- Submit six (6) hard copies of your proposal by October 15, 2003 to be considered in the first round of this Certification process. They should be sent to:

  George McCahey, MSW
  Division of Children's Behavioral Health and Education
  Department of Children, Youth and Families
  101 Friendship Street
  Providence, RI 02903

- Make sure all letters of support, cooperative agreements and all other required forms are signed by the appropriate authorized representative.

D. Next Steps

- A dated, written confirmation of DCYF's receipt of the proposal will be provided to all applicants.

- On September 10, 2003, from 9-12 noon, there will the first of two Technical Assistance Sessions held at the Department of Labor and Training, Pontiac Ave., Cranston, RI, Building 73.

- The second session is scheduled for September 22, 2003, from 1-4 PM, MHRH, Building 54, Division of Developmental Disabilities, Howard Ave., Cranston RI.

- Appropriate staff from the Department of Children, Youth and Families as well as the Department of Human Service will provide technical assistance to applicants regarding the proposal process at these sessions.

- Within four (4) weeks of a complete proposal submission, the applicant will receive a written response from the Review Committee. This response may qualify the agency as a Certified vendor or it may request further clarification.

- If required, the State may request an additional Technical Assistance meeting with a provider if the original proposal requires such an intervention to clarify any major areas of the submission.